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INTERVIEW WITH CAPT JAMES J. WARE, DC, USN

CONDUCTED IN TWO SESSIONS

BY

JAN K. HERMAN, SENIOR HISTORIAN, BUMED
AND
LISA BUDREAU, PH.D., HISTORIAN, BUMED
ABOARD THE USNS *COMFORT*, BALTIMORE, MARYLAND
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JAN K. HERMAN, SENIOR HISTORIAN, BUMED
ANDRÉ SOBOCINSKI, DEPUTY HISTORIAN, BUMED
AND
LCDR KAREN M. STOKES, DC, USN, BUMED
WASHINGTON, D.C.
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OFFICE OF MEDICAL HISTORY
BUREAU OF MEDICINE AND SURGERY, U.S. NAVY
WASHINGTON, D.C

This interview was conducted aboard the hospital ship USNS *Comfort (*T-AH-20), pierside in Baltimore, Maryland, by Jan Herman, Senior Historian, and Lisa Budreau, Ph.D., Historian, Office of Medical History, Bureau of Medicine and Surgery, U.S. Navy. In this session CAPT Ware describes his experience as the commanding officer of the medical treatment facility of the *Comfort* during its deployment to Haiti for humanitarian relief following the devastating earthquake that struck that country 0n 12 January 2010.

A: (The tape starts in the middle of a conversation.) Impossible is not the word I would use for it, but what I would say is when you put a team together, you use the expertise of each individual on the team, and you need to pull what their expertise is to the table, to bring it out. Jim Collins, who wrote *Good to Great*, an analysis of Fortune 500 companies leadership and excellence, talks about that, and I'm a firm believer.

I'm a consensus builder, and for the people who were on my team and who I work for, I bring out and find the best in what they do. If it is problematic that I can avoid their limiting factors, whether their temperament or their personality, I'm probably not going to change that. But what I look for in each individual is what they can bring to the team in a positive way. A mission in the United States military, or any organization for that matter, is all about figuring out how to get the mission done. Nobody, whatever the mission is (in our case a medical mission), is necessarily the best person to lead that mission because of their innate skill set, and that includes me. My innate skill set is not that of a surgeon, but what I bring to the table is the ability, I think, to pull the best from the people who were on the team so that you get the Jim Collins thing: the right people on the bus at the right time in the right position, and then let them do what they're good at, or reshuffle the deck just enough so that you get a synergism.

We can't predict what the next disaster is going to be, where it's going to be, and what our challenges will be, but what you need to do is to get the best people on your team, and then figure out a way to work with them to pull out their best skill sets. That's the way teams succeed, whether it's a sports team or whether it's a corporate team.

In the military it's a little different because on the operational side you may have to order people to go into battle who may lose their life. A military commander may have to make those calls knowing that a proportion of the people that he directs into combat won't come back.

Thank goodness, for a medical mission, I don't necessarily have responsibility to that great of an extent most of the time, so it's not one of the things that I focus on. Rather, I focus on pulling in the skill sets of the people that I have for the greatest benefit. As in missions that I've had in other circumstances, I'm always looking at the people and what is their they bring to the team. And it doesn't matter if it's the lowest person; what do they bring to the team?

I think there's a group of people who are lumpers and another group of people who are splitters. (I didn't come up with this, but one of my mentors did.) Lumpers are people who figure out a way to consolidate what's good around them and bring them together to accomplish the mission. Splitters are people who may be smarter, may have much bigger egos, who find ways to divide and. From my viewpoint I'm a lumper. Whenever I start a mission I want to make sure that I epitomize that to the people that work around me. I think you always have to be aware of people who are in it specifically for themselves; that's a human trait you have to be aware of.

Q: I want to take you back before the Haiti mission to when you were selected to be the skipper.

A: Two years ago.

Q: You had taken part in Continuing Promise, so you had some experience with the *Comfort* …

A: …while I was the commanding officer, that's correct.

Q: So you were familiar with the fact that these ships are not being used for their intended purpose when they were built to support the Cold War, but now for humanitarian assistance. When you heard about the earthquake, how did you hear that this ship was going to Haiti?

A: I was driving home to Annapolis and the Haiti earthquake was on the radio. I said to myself, "This is absolutely going to be something that the American government is going to want to get involved with." Although the initial numbers were very low, as the news came on at 5:30 in the afternoon and they talked about a 7.0 earthquake, I knew that we would have a national response to it. But my thought was that the ship wasn't ready to go. I also knew the USNS *Mercy* had just ventured up to San Francisco having an overhaul done, so they were out of pocket as well. My first reaction was maybe a gray hull [U.S. Navy warship] would go out of Norfolk. But I got a phone call from Tom Neegus, who was the commodore on our last mission [Continuing Promise 2010]. He said, "J.J., it looks like I'm going down there. We're spinning up the ARG out of Norfolk and possibly could be going down there. I sure would like to have you with me." I mean, this was in the first two hours.

I said, "Well, I don't know. Our ship is down and I don't know if we could spin up, but we'll keep in touch. Good luck." When I got home and turned on CNN the reports were fairly sketchy. I don't know if they had anybody on the ground in Haiti at that moment, but the magnitude of the disaster began to kick in. Because I'd been involved with other tragedies and knowing how numbers are, you know that the first set of numbers they give you are almost always underestimated. I'm sitting there with my wife going, "I really think we might get called on this."

She said, "Well, they've got other ships; you just came back."

And I said, "No, I think we might get called." After seeing the news and staying up until about 11:00 that night trying to get as much information as I could, I decided that we were probably going to get called, and began to think of who I needed to contact. This was late at night. I don't know if I'd talked to the XO that night. We may have had a

phone conversation, but we were all aware that within that first twelve hours that we were going to be going. So I got a good night's sleep.

Coming to work the next morning, I thought to myself, "Who would I need to execute the mission?" I knew that the normal process of getting the ship underway and ready to go would all be taken care of; we'd done it for Georgia. Remember the Georgia mission? [Georgia Humanitarian Assistance Mission 2008] We'd already gone through the planning for that HCA [Humanitarian and Civic Assistance] mission, so I knew the processes that needed to go on, and I knew that the staff could probably execute those if we got the call. I knew that my morning was going to be filled with providing data to higher authority on where the ship was, which is what we always do, the MSC [Military Sealift Command] and ourselves.

There was a group of people that I wanted to make sure were taken care of who might serve a purpose, and that was the NGOs. I knew that NGOs would be a part of this, but I didn't know how. I also wanted to make sure if we got the call that USAID, which is the State Department component for health care (although it doesn't belong directly to the State Department), would be engaged. So when I got to work that morning I called up three civilians who had been on prior missions and had MOUs EXPLAIN--MOU WITH WHO?. One was a retired captain, Claire Pagliara, who ran the medical operations for the CP7 mission (sadly, her husband was killed in a motorcycle accident about three weeks ago). I kept a Rolodex of people that I knew, people that I wanted on my team, and I called her up out of the blue. "Claire, this is Captain Jim Ware. Are you watching the news?"

She said, "Yes."

"What do you think about us going to Haiti? I don't know that we're going to go, but if we do go down there, if you would come as an NGO coordinator it would be incredible."

I'm way out of the box here; I've "put myself on report" -- the fact of the matter is I needed somebody to coordinate NGO activities. She was a Navy officer with NGO experience who had an MOU because she had worked with Project HOPE (although she wasn't working with Project HOPE at the time, nor had she intended to). But I needed somebody to coordinate that, because I knew that we could have hundreds of NGO civilians onboard, and the most difficult thing on my last mission before this was the coordination piece, which fell to the DFA. I knew that if we were rapidly going to go from 50 to 1,000 people that I needed a coordinator, so I called her up.

I also called up another guy, Marty (I can't remember his last name). He was another guy I had in my Rolodex. He had been an administrator for Operation Smile on the *Mercy* when I was onboard, and was a humanitarian. There's a difference between people who were just good Americans and humanitarians; everybody can't be a humanitarian; there's something in their heart. I saw this not only in Claire, but I saw this is Marty on the *Mercy* mission almost two years ago. I hadn't talked to the man since that time, but I knew he was a good administrator and could help with these NGOs to do the administrative piece for Claire if we took on NGOs. I called him out of the blue (he works for the FAA, I think). "Marty, if we get NGOs, I'd like you to be part of the mission to help coordinate their administrative issues, such as their flights and other things."

The third person I called was Suzette Steins. She's a dentist in private practice in a little town in North Carolina who had been on a mission with us. She's a Haitian American who spoke Creole. I called her. "Suzette, this is Captain Jim Ware calling from the *Comfort*."

She said, "My God, Captain Ware, how are you?"

I said, "One of the most important things we need on the mission are translators. I need somebody that can coordinate those people, but I don't know where I'm going to get them from. I don't know if from Food for the Poor, which was our last translator group, or the American Red Cross, but I need somebody who can help coordinate the translators. I don't know how we're going to do this, but I might need your help. Would you stand up and answer your country's call for you?"

She says, "I don't know, but if I can, I will." She ultimately ended up saying that she would.

Now, none of these people were sanctioned to come on the mission, but they came. I probably broke the rules in a sense, but I knew that they would be valuable and I knew that we take civilians onboard on a lot of these missions, so I was just trying to lean forward and figure out the best thing to do to get them onboard.

The other person I called was the USAID person at Southern Command. I said, "I've got to have you involved on the ship. I've got to know what's going on on the ground in Haiti when we get there." My vision was to have a group of people onboard who could orchestrate the medical mission to some degree from here. We didn't have to be the lead agent, necessarily, but I knew that the more coordination I had on our team, the better off we would be in getting NGO people onboard, which ended up to be exactly the case.

The USAID sent me two people: Clydette Powell, who I'd recommend that you speak with as part of the bigger picture; she's a doctor for USAID. The other one was Rob Ferris, who had a huge part of the mission in Haiti. What ended up was I literally demanded that USAID send me somebody, because they never get involved with the military; they're not comfortable working with the military. My personal view from my experience in the past is they think the military shouldn't be part of these missions. I think it's a money issue, but anyway I really wanted them to be part of us. We work for USAID when we go into these countries on these disaster relief operations. They're the lead agent, and I fully understood that. That's why I wanted to have somebody onboard the ship who could give me counsel, who could be a liaison, could give me a window into what their organization looked like on the ground in Haiti so when we got there we could be most efficient.

There were five people who ended up coming to the ship: the three I mentioned and the two USAID people that I put in the medical operations planning cell, and they all arrived before we left Baltimore. Thank goodness we had about 76 hours.

Q: At this point, you haven't gotten the word?

A: Between 0900 and 1100 on the 13th, we'd began to push information forward up the chain of command on the status of the ship. We didn't have radiology; we didn't have an angiography suite; we didn't have supplies. The water in the aft of the ship was down, so none of the toilets worked in the aft. The steam wasn't up, so our sterilizers, which is very important for the steam, wasn't working. The electricity had been up and down, so the IT suites, which we had been changing over from a legacy software program that was not fleet serviceable to a fleet serviceable program called *Compose*, had been transposed to the ship, but wasn't up and running to the extent needed for a full-time operation. So from 9:00 to 11:00 in the morning on the 13th, it didn't look like we were going to get underway. I think most of us realized that this was an opportunity for us to do a good job. I was leaning way forward. I was crossing every boundary I could cross to ensure that if we were going to get underway that I would have the resources we needed.

At 1100 the MSC [Military Sealift Command] sent a message up the chain of command on the status of the ship. It was a red light, yellow light, green light type of report, and the medical piece was all yellow. The bottom line was that nothing was an absolute show stopper for the fleet, but we were not ready to go. Since the 13th of November, we had been under the same conditions: the electricity up and down; IT up and down; steam up and down. Although they plan on a 30-day period of time for repairs, things happen with contractors -- and guess what? They don't want to pay them over holiday periods,

because they don't work as much, so things seemed to go from the 30-day cycle to a 45-day cycle. We went through the Christmas holidays and things were very slow.

Coming into the new year, things started to get ramped up. We were very close to being ready, and that's why we ended up getting underway, but a lot of the things that the ship needed to actually make it operational still affected us. It all rolls downhill: steam, electricity, water. The fact of the matter is we got the word on Wednesday (I've got the document that says 1100 on the 13th.) We fed the data to the ship's master and he fed it to MSC, then to Fleet Forces Command. I got the call about 1300 that at any hour now, "You're going to get underway."

The earthquake happened about 18 hours before, and now we're going to get underway. Then the question comes, where are we going to get the people from? Who do we need to come onboard the ship? Well, we'll definitely need different types of people than we had on the last mission [Operation Continuing Promise 2009], but we can start out with that as a template. Are we going to use Army and Air Force like we did on the last mission, or will it just be Navy? And how will we get the NGOs aboard? I started calling the people I called earlier and said, "Hey, it looks like we're going to go, can you make it?" Of course, they had to rearrange their whole life. I mean, these are people that I haven't acknowledged enough for what they did as civilian Americans. We didn't pay them anything; they just showed up.

Similarly, people at Bethesda: the surgical staff -- Tim Donahue, senior surgeon; the medical staff -- Arne Anderson, pediatrician; senior medical officers, primary care; they were getting the word that somebody was going to go, but there's only a few people on the hook to actually come to the ship, and even that's debatable. The only people that were certainly going to go were the 52 onboard the ship as the cadre crew. I got in touch with Bethesda and I told BUMED in the afternoon, "We really need many of the people that came on the last mission. We need that expertise." They were very inclined to send many of the same people, and it ended up about 30% of the people who came on this mission had been on the last mission; so it wasn't everybody. People come and go, and some people from the prior mission had been identified to go to places like Afghanistan and Iraq. Navy medicine is stretched very thin, and people were doing other deployments.

Then the question comes up: What about the NGOs? Can we get those aboard? Somewhere in the next 24 hours we began to indentify the types of people we needed. Orthopedic surgeon is one that will continue to come up, but it was decided by the Surgeon General that we would use the package that we had on the shelf. It wasn't the perfect package, and a lot of people weren't happy with that, because we didn't have enough orthopedic surgeons. But the idea was to get us underway. How would we get our

food? How would we get our medical supplies? And how do we get our people? Maybe we would stop in Norfolk, Jacksonville, and Miami before we got to Haiti. It ended up we didn't; we just got underway as fast as we could, twice as fast as we were required, to get down to Haiti as quickly as possible.

Q: The requirement is?

A: Five days, 120-hours.

Q: And you did it in . . .?

A: That was Wednesday afternoon, and by sunset on Friday, two and a half days later, we had everybody medical aboard. We were getting them in their racks, and we had loaded 600 pallets of food and medical supplies. I remember coming in Friday morning, and there were trucks all the way out to the road -- big, huge trucks with medical supplies and food, and the cranes were moving up to the ship.

All of my guys are running around like beavers trying to make things happen, because the ROS crew has to get the food and the equipment in the right place. If you walked through the medical space you'd see things covered up, and if you walked through the scullery area and the galley it was the same thing. Other people are coming aboard to unwrap and get the galley ready to serve 6,600 meals a day once we were fully manned.

Thursday and Friday were spent trying to figure out who should be aboard. Finally we decided we'd go with the smaller 561-man package, and the Surgeon General and Admiral Cullison [Deputy Surgeon General] coordinated to get 350 additional medical people into theater.

And this is what I'm really proud of. We were so fast getting out of here that we were almost three days ahead of the schedule predicted for us. In one of my emails I said we were going to be in Haiti Saturday morning (I think we got there Thursday night), and somebody wrote back and said, "Don't say when you're going to be there." This was the only time operational things seemed to get in the way of just trying to pass information to everybody that needed to know. "Okay, well Saturday is when I thought we were going to get there, and people who were planning to come in Saturday or Sunday needed to know that because it sounds like we're going to bypass every port. We're not going to stop in Norfolk or Jacksonville."

Q: When you say, "Be there," where do you mean?

A: The port in Haiti.

Q: On Saturday?

A: Yes, initially it was going to be Monday, but then we left here at breakneck speed. We went by Norfolk and I'm thinking, "We're going to get there two days early. We're going to get there Saturday." So we're steaming as fast as we can. But we had food still coming to us. We had 600 pallets, but we needed more. We had medical supplies coming that we had ordered. It all didn't arrive here by Friday night (remember we left at the break of day on Saturday).

Q: Were these going to be UNREPs [underway replenishment]?

A: They were, but what was most important to the people of Haiti, as a showing of solidarity that we were going to help them, was to get the ship there. We had 520 medical people aboard; some of those people still hadn't gotten to the ship because they were coming from San Diego and had to fly in. But the idea was that after we started to roll we needed to get to Haiti. We needed to be in port as quickly as we could. Thank goodness we did, because everybody was waiting for the hospital ship to get there.

Q: Now while all this is going on, what is happening with the fact that you have a water problem, and you've got all these other issues?

A: Well, we solved a lot of those issues from the 13th to the 15th. We were the focus of everyone's attention and helping us was a large group of contractors who were called in here and worked around the clock until the night of the 15th. Contractors were fixing the steam, the water and the plumbing to get it right. The civilian mariners can tell you those stories. The air-conditioners were down and were problematic going down to Haiti. MSC cannibalized the *Mercy* in San Diego for things that we needed right away, and then ordered the replacement parts for the *Mercy*. They were flying air-conditioners and power generators across the country to us to keep us maintained, and the mariners could tell you about that. Everyone was focused on us.

We wanted all medical personnel onboard by 1900 Friday night, because the Surgeon General came aboard and gave us a pep talk. Of course, we had all been busy trying to make sure our families were OK. Some of us had been watching television reports about Haiti, and he explained to us that this was going to be a huge event and we might be there for six months; "but you've been well trained to go do your duty," which is the way that I would explain it as well. He finished at 1900, and he and I came to this room we're in

now and had a personal conversation. He was obviously in full support. He wrote down his telephone numbers, and said, "If you have any issues you can give me a call." I still have that piece of paper.

The point is we were moving at breakneck speed and trying to prepare for the unknown, because we'd never done a mission like this. But when you don't know what you don't know, it's sometimes better from my perspective, because I had been involved in these circumstances before. I had a sense of where we were going and what we would need, but it wasn't medical expertise; it wasn't the number of people. It was the temperament of the staff, who needed to know, as Horatio Nelson said in the Battle of Trafalgar, "You've got to do your duty." You can't let the mission be deviated by your own personal issues, because this is such a traumatic event. You've got to do your duty; you have to develop the mettle, because there would be a lot of sad moments.

Over and over and over again, day after day, we all experienced sad moments, but you have to keep going. You have to look after your shipmates and you have to be aware that some people, even the intensivists in the ICU, who I thought would have the most mettle to handle death and dying, had their moments. I would also have my moments seeing a sad situation, but I would focus more on my staff to make sure that they were strong and capable of doing their job that on a daily basis can be emotionally trying. I emphasized over and over again that good food and good sleep are two things that are very important.

Q: You're steaming; you're underway; you're out at sea. Do you have your full manning at this point?

A: Full manning is a difficult point. If you asked the staff, they would say, "No, we didn't." What we had was the number of bodies prescribed for our initial mission of a 100-bed hospital, to get out of port quickly, and to scale up to a 250-bed hospital. (By the way, I hate the use of the term "hospital beds".) The fact of the matter is we could man 250 hospital beds with our nursing services in order to get down to Haiti and start the medical mission, but we needed enough physicians to make our medical capability fully operational, which we didn't have when we left. However, the NGOs and Navy Reservists would provide hundreds of bodies for that mission. So the idea was to get underway, to get us coordinated, to get us activated.

We got there early. I thought we were going to get there on Saturday, but we got there Thursday night. Beginning the second day we were in country, the 22nd of January, we received another 300 individuals who came to provide medical care; these people began showing up on Saturday and Sunday. When we got in-country we didn't initially have maximum capability -- and the staff will talk about that -- but the fact of the matter is that

was because we got there in such breakneck speed. These new people who came onboard had been prescribed by Navy Medicine, and the Deputy Surgeon General had been orchestrating to get them to us from all points of the country. That effort was successful. It's just that we were so efficient in getting down there that we were initially understaffed, and the MSC community didn't quite appreciate that.

Q: The initial group of folks who left with the ship from Baltimore -- were these Navy folks?

A: Yes.

Q: Were they Reserve, unlike some of the other missions where they yanked active duty people?

A: They were mainly active duty people from Navy hospitals, because most of them had 24 hours or less to get their sea bags together.

Q: So they would have been from Bethesda and Portsmouth?

A: …and Pensacola, and some from San Diego. They showed up late on Friday night.

Q: Here in Baltimore?

A: Yes. We also got another group of 76 people who showed up Friday night. They were the security unit, but they weren't really part of my unit [the medical treatment facility] and I wasn't expecting them. When somebody just shows up and says, "We're here," and they've got all their bags – well, the DFA and her staff were already putting on over 500 people, and that was daunting.

BUMED had solicited eighteen journalists and photographers, and they also showed up that night. Well, they're not getting special treatment. I mean, I was glad to have them, and we had nine handlers, but I wasn't too worried about having to make them comfortable.

Q: Did you not know? Did anybody prepare you?

A: I knew that they were going to come, and quite frankly, it was fine, because I had dealt with the media for months. I mean, I'd been to every country covered by Continuing Promise and interacted with the ambassador and prime minister of those countries, along

with the ministries of health. I'd had a lot of training, and I was up for the task. Plus I have a belief that in the medical area you want to be transparent. We had a mission to do. They had been brought aboard, and I was very happy to have them. I wanted us to tell our story, much like we're doing here, and they did.

Q: What about the security?

A: It was just another part of the puzzle that you solve when it comes your way. There were so many things going on. Remember, we're trying to load 600 pallets of food. The main thing that I stressed on Thursday and Friday was, "I have to have my medical supplies." I was very demanding about that. I was dealing with people external to the Navy because these supplies are purchased from various venders. I was dealing with an admiral at MSC, and I told him, "You know, I don't think we're going to get but 75% of our medical supplies and I need those."

But the fact of the matter is, even as I was leaning forward and being very direct with people who were senior to me, looking back on it, they could only do what they could do. I had to push the envelope as far as I could without getting fired. I had to do that on many occasions, but I was waiting for the other shoe to drop. When everybody in the unit is on an equal footing with how important the mission is, maybe the people above you are not. That's one of the things I came to realize. I was at the point of the spear, but people behind me are giving me advice that's just not the right advice, and sometimes I just have to do what I think is right, whether I'm right or wrong. That's not even uncomfortable at that point; you just have to do what you have to do.

By Friday morning, my staff was stressing over the supplies they needed. I began to make sure that I had touched every possibility to make sure we had 100% of the supplies. The people behind the scenes were stressing too; they were working 24/7; and they asked, "Can we get the supplies delivered to Norfolk?" My supply officer is going, "Well, are we going to stop at Norfolk?" This is the Thursday or Friday morning before we left.

I said, "We might. The word still is that we might stop in Norfolk, Jacksonville or Miami." Well, if they can't get the supplies to us in the next 24 hours, maybe they should send them to Norfolk, or maybe they should send them to Jacksonville." Those were real issues. I mean, journalists aboard, I was glad to have those, and security people that ended up coming late, okay, there's room at the inn; that wasn't really important. However, medical supplies were critical. Navy medicine had decided what the packages would be and directed, "That's what you're going to get. We'll develop it as we go along,

and you'll get additional bodies." Thus that's something I'm not going to stress about. Let's take care of the people I've got; let's figure out who's onboard.

Once again, I'm needing staff. I need a surgeon. Okay, what is his job going to be? Where does he fit into this team? What is his temperament? What is his ego? How much knowledge does he have from prior experiences? Where has he been? Has he been to Afghanistan? Iraq? What's going to be his temperament and his mettle when people start rolling aboard who have crushing injuries, amputations? Is he or she going to have the mettle not to whine about things they don't have, but to get on with the mission and to show leadership, to set an example? That's so critical, because if you have people who dwell on their own sadness, that can be problematic the moment when you need them to step forward and make good decisions and just get on with it.

I had a very good staff; I had an excellent XO. He and I had the same mindset, and I let him run the internal aspect of the ship on a day-to-day, moment-to-moment basis; that's what XOs do on Navy ships. Thus I could look forward and try to figure out where the rocks were. But in addition to that, one of the things that was so critical to this mission was our interaction with the shore establishment, with USAID at the MC [Malaria Consortium?], with the medical people at the MC, with the NGOs who were in country, with the local hospitals in country, with the Minister of Health, Dr. Alex Larsen (who had been on the ship before and who I knew personally). Those are the things that really provided the necessary INTEL so the mission could be successful. At the end of the day, they were the heroes of that part of the mission.

If you take on 500 patients or 1,000 patients you're full ?? What does this mean??. Every patient that came aboard that was unconscious and needing surgery in a most critical way, not only needed to have their surgery done, they needed to have their life saved. We needed to save their limbs, but we also needed an exit strategy for where they would go when we finished with them, and how fast could we turn them around to save their life, limb, or eyesight and get them off the ship? Could it be six days, seven days, eight days? The average length of stay for a patient was seven and a half days. We were there 30 days; 35 days once we were bringing patients on. This doesn't make sense.

But where would the patients go? Would my doctors accept just dumping them back out on the street? Well, absolutely not. Well, where could they go? The country and the infrastructure were destroyed. The seven main hospitals that we knew about had been destroyed and even if they hadn't been, there were thousands of people waiting to have medical care. Haiti was not the place to put recovering patients for the best medical care. So we had to develop a sense of what was on shore, and that's called medical operations.

Captain Andy Johnson ran medical operations; he's now in Portsmouth. His staff had to develop a medical plan to move patients off the ship for good follow-up care, and that was critical because, quite frankly, no one had had a solution for that; there was no solution to be had. As I mentioned, I went ashore the first two days to find out what was going on and it was very immature. There were not enough people in the medical planning cell to develop a plan for us, and within 72 hours of me going ashore we were going to be completely full. We're talking about the biggest problem for a hospital in this hemisphere with more patients in 72 hours than you could possibly shake a stick at -- over 500. We needed a place to take the patients that we fixed ashore, but we didn't have a solution. Captain Colleen Gallagher, a nurse who's at Bethesda, was one of the heroes in that area. I can give you their award citations, if that would be helpful, because they're the people that made these things happen.

My guidance to Dr. Andy Johnson was to go out and find places we could take these patients. They had to go and find the doctors, but they were was not in Port-au-Prince. They were in areas that were 40 and 50 miles outside of Port-au-Prince, so our helicopters had to take our people there to interact with the NGOs who were there, specifically Partners in Health, and then determine not only how many patients they could take but what kind of patients they could take. We had paraplegics. We had 44 people with spinal injuries. We had 16 neuro injuries. We had over 650 orthopedic wounds and injuries, along with other types of problems. We had preemies. We had NICU patients. We had children that were born with very poor survival chances whose mothers had crushed pelvises and it was determined by the doctors that to save the mother the baby had to be born.

We have a baby who's born at only 26 weeks gestation. This was the story of Isabelle, a classic story of a Haitian baby who should have died. In fact, after three or four days the staff said that the baby was not thriving and was going to die. They had Isabelle hooked up to all these different medical monitors. They decided she was probably not going to live and we needed to move on, because we had all these other patients. But as they withdrew medical support the baby got stronger, and this was like a battle cry for the whole ship. Everybody knew that there was a baby named Isabelle and was she dying. Or was she living? She was coming back and you could hear the people in the corridors, "Isabelle's getting better; she's getting stronger." The medical staff rallied around that. It sounds weird, but she represented the will to survive of the Haitian people. If you asked the doctors who saw her that's what they came away with.

I don't know if you're aware that Bob Hawley, the master of the ship, died?

Q: You mentioned it last time, yes.

A: He had a heart condition, and he died down in Norfolk. One of the things that he brought to the team was an international piece. I'm the captain of the hospital, but he was the captain of the ship. He was not a Navy guy because he was a civilian mariner, but he loved the sea. When other ships would come into port, he would contact them. "Would you like to come over and see our ship and see the hospital?" He'd say, "Hey Jim, I'm going to bring the Italians over, the Mexicans over, the Colombians over." And I'd say, "Okay."

Well, for me, these were very small medical groups. I mean, I had 1,000 medical people onboard, and so a couple of new doctors who would come in was not really that critically important for me to stop what I was doing, but I appreciated that he was making those overtures. When they would come to the ship, he would make sure that I would meet them, and I'd introduce them to one of the flight doctors or emergency room doctors. He loved that, and then he'd bring them downstairs and have dinner with them. Of course, his job was very busy, but I guess mine was busier or I just didn't know how to manage my time. He'd say, "We're going to have dinner tonight." And I'd say, "I'll be there if I can." But most of the time there were other things that were more important.

Bob loved to interact with the international navies, and I give him credit for that. He would walk them around the ship -- it's his ship, right? -- and very proud of it -- and show the different departments and talk about the patients. (Although that wasn't his area, he would enjoy doing that.)

Well, Baby Isabelle came to his attention, and he would ask, "How is Isabelle doing?" He did a very nice PowerPoint slide about that child, and he became her biggest champion. Now here's a captain who's a ship driver knowing one of the ten preemies we had on the ship. It became a rallying cry for him as well as the doctors. That baby who survived and her mother became a sense of who the Haitian people were. They were survivors.

There's one other thing. When you're going to go into surgery they we do a hematocrit to see how many red blood cells you have in your system. The number is usually between 16 and 23. Well, for some of these Haitian people it would be down to five, six, or seven. A surgeon would look at that and go, "Oh my God, the person needs a transfusion." Well, the fact of the matter is these patients were actually surviving with this. They're very strong and resilient. We gained a huge amount of respect from these patients that we saw onboard, and they've become the story of legend, and certainly Isabelle is one of those people.

Q: What happens to the babies when they go back and there aren't enough incubators in Haiti?

A: Great point. To lead you through the analysis, we had ten babies born here to mothers who were injured, some of them long bone fractures, some of them pelvic fractures. One of the deliveries was a set of twins. We had intensivists in the ICU who were pediatricians, some of them civilian. One I'm thinking of was a guy from Chicago who probably was an anti-war demonstrator in the 60s and had long hair. He got a very short haircut, much shorter than mine, and he put on a uniform and said, "I'm going to really surprise the people back in Chicago, because I'm so proud of working on this team." He was a great example of the people. He would work 20 hours a day, and I'd have to ask him to go down.

For him and the nurses and doctors like him, one of the things that was very important was that we be able to verify the care ashore in Haiti.

The medical operations staff would go out to these hospitals and and see if they had the capability to follow up the care of the patients we were releasing. The doctor is the patient's advocate, and they do not want to release a patient to a lower level of care unless we could verify its capability. Captain Gallagher went to these medical facilities to number one: determine if they had room, and number two: determine if they had the right skill sets. Specifically they coordinated with Partners in Health. Dr. Paul Farmer is a medical healthcare pioneer in Haiti, and his Partners in Health had set up medical clinics in the mountains fifteen years ago, in an area that is 30 or 40 clicks out of Port-au-Prince. He's from Harvard and he'd done most of his work in the area of HIV, but also with preemies and small children. So they had some capability for incubators and other things that we worked with. His organization was a very important one. Also, Sacred Heart [Hopital Sacre Coeur] had similar facilities. Now they weren't, dare I say, world class, but they did have the capability to monitor and to help some of these children thrive. Captain Gallagher was the interface for those individuals.

Q: So they went from the ships straight to an NGO?

A: Yes, that's exactly right. Initially, most of them would go from the ship either to a holding facility on land which may have been the Army or the Air Force facilities that we'd already liaisoned. After about day ten we started to liaison directly with the NGOs. There were 22 organizations that we used in some capacity to move patients to, and we would take patients from as well, It was a two-way exchange, although, most of our patients were going back to them, because we had over over 851 patients that we needed to get out.

Q: To go back to the manning issue; when you arrived in Port-au-Prince, the folks you had onboard at that point were Navy?

A: That's exactly right, except for the small crew that I had gathered and brought onboard.

Q: Those five people? List??

A: They weren't medical; they were going to help me with building our team...

Q: But they arrived here in Baltimore, so they left with you? That was your personal team?

A: Yes, that's right.

Q: So you arrived in Port-au-Prince Thursday, and now you had the NGOs? Now were those NGOs in Haiti at that point? Or had they begun to arrive? How did that work?

A: Project HOPE is very forward leaning and they had two people onboard that I used for my medical cell. I was thinking in terms of the CP-9 mission where we coordinated all the medical missions from the ship with the Minister of Health and the Ambassador. My frame of reference was that type of a mission where we would monitor, control, and coordinate from the ship. Two medical directors from Project HOPE came aboard, and left Baltimore with me with the idea that they would help plan who from their organization needed to be there and how we would help them. BUMED must have helped them get aboard along with a lot of other people, like the journalists.

I'll get back to the NGO piece, but I want to say one thing since you're taping this. There were 300,000 people injured and there were 200-250,000 killed in a circular area around Port-au-Prince. We were about a mile and a half off the coast of the city, and everybody who had been injured or killed was in a 12-mile radius of where the ship was -- half a million people. There was another million displaced in this circle, and most of them were living in tents.

If you've never been to Port-au-Prince you can't appreciate the type of city that it was before the earthquake. It was people upon people upon people upon people, hundreds of thousands, in the smallest of areas. There were three million people in the city, and it's a very small city. So it was quite obvious that we were going to be in the middle of everything. The medical facilities in Haiti re-opened and they did what they had to do, but it was little better than Civil War medicine. If you can imagine medical facilities with

a few doctors, two nurses and 1,000 patients, and the worst of the worst would come in. If the patient was outside the door and they were going to die, they died. If the patient could be saved by amputation, they brought the patient in, closed the door and they sawed; then brought the patient out with a tourniquet. They didn't do this to a few patients; we're talking 4,000 patients in these small medical facilities. If the doctors who were in country weren't themselves injured, they more than likely had friends and family killed or injured, because there was at least 500,000 people who were killed or injured.

The point that I'm getting to is that if we use a number of 300,000 people who were injured, there was no medical facility in country that was any more advanced than, really, Civil War medicine. They might have been able to use morphine; they might have been able to use some other narcotic to put the patient down before they had to remove a limb. It's been estimated they removed between 4,000 and 5,000 limbs within that 12-mile area. When we got here seven and a half days after the event, every one of those doctors and nurses were exhausted. There were thousands of people wanting their care, and thousands of people were dying at their feet, or had died and they had nowhere to put the bodies. I don't know if you've seen the pictures. It was so important to get there early, with or without the full staff complement, to provide those people hope. When we pulled into port, I believe that people from every point said, "The Americans are here. They're here to help us. Let's get our patients out there." And they started to come, literally by the hundreds.

Our trauma surgeons that we sent ashore on days two, three, and four, were triaging up to 300 people a day to decide who should go to the ship. They were picking up to 60 people a day, but turning away five, six, seven, eight times that many. These were critical patients. Some of them would die at the site; some of them would move on and get lesser medical care but still survive. So 300,000 patients were distilled by us into about 800 patients we saw over the next 30 days.

For the people who can't visualize what was going on there, we didn't take all comers; we just took the worst of the worst. The people who made those decisions were our trauma surgeons, Dr. Zsolt Stockinger and Dr. Richard Sharpe, who'd served in Afghanistan and Iraq, and they both said this was much more intense. In fact, Sharpe said because of the numbers it was five times more intense than any of the IEDs he had managed over there.

We had a medical staff that could handle a lot of patients, but you could never have enough staff to handle all the patients. With the number of beds we had, we could take up to 100 patients a day. Every six to ten minutes a helicopter would land with two patients. If you do that for 14 hours of sunlight, which is what we had, you'd have 100 patients, [?

At two patients every six/ten minutes for 14 hours this would be 168-280 new patients a day.??] and that's pretty much what we did; a little less than 100 the first day because we filled up 100 beds the second day, 100 the third day, and by day five we were filled. And remember, the bed space onboard -- we talk about 1,000, but we really need to get away from that. The bottom line is we had 500 beds that emergency medical people could access on the same level, because the second-tier of patients was on a higher rack.

Q: How many days were you into the mission in Port-au-Prince when you started getting some of the NGOs aboard to help out?

A: There's two different groups of NGOs. The NGOs already in country, I think that's what you're alluding to. The University of Miami had done a great job at flying initial medical support into the airport, and they were doing whatever they could do to save lives, but most of it was amputations because of the huge number of patients that were there. Some of the doctors from that NGO came aboard the ship, but they didn't stay with us full-time; they just stayed short periods of time. They may have done surgery with us to kind of get the sense of what we were doing on the ship to go back and tell their folks.

The Project HOPE individuals had to go through a wicket from Fourth Fleet to be flown from Jacksonville, Florida to the ship. It took probably six days before we got that first group of 25 NGOs. There were some trauma surgeons in that group, some orthopedic surgeons, and some very, very critically needed pediatric ICU nurses. So that, shall I say, was a slow process. We had gotten down there very quickly. We had set up a planning cell onboard the ship, and I had full hope that we would get them very, very quickly, but the process seemed to move a little bit slower.

But remember, there were a lot of things going on at the airport. My understanding is the American government, at the request of the President of Haiti, had agreed that the Americans could control the air space. But there were countries from all over the world trying to fly in medical gear, medical people, food, water, and other things. The airport at Port-au-Prince was like a zoo, and to get people in there was very difficult. There were lots of different things going on, and I can't speak to all of that. All I know is we were sending the signal that we needed more orthopedic surgeons; we needed more pediatricians. Navy Medicine got us some of those; I remember they showed up on days one and two.

Interestingly enough, Navy Medicine and myself and some of my staff from the first day going down would have telecons, and we were going, "This is what we think we need." We had a direct line to Navy Medicine to build up our processes. Admiral [Michael] Cowan [Something sounds wrong here. Cowan had been retired as SG for several years;

VADM Robinson was SG!] and Rear Admiral select [Forrest] Faison, on the other end of the line, were trying to do everything they could, but they were many levels away from us and were not part of the operational chain -- and the operational chain wanted to control some of that chatter.

Q: Did those NGOs -- let's say the Project HOPE people -- have that database?

A: Right, they started calling me as well, and I had to defer them to other people because I realized that I was way out of my chain of command. Although I had leaned forward early on to get people, I needed to refocus to what was going on in the ship.

Q: So that whole deal with the NGOs -- Project HOPE-- was handled elsewhere?

A: It was, yes.

Q: When they started arriving five days into the mission, did they come in through Port-au-Prince and were helicoptered out to the ship?

A: They did, yes. There were two ways folks got in. The military active duty or Reservist people that came in on the 21st and 22nd flew into Gitmo and then came into Haiti on a military flight. There were some 350 more of them who came to the ship. We sent some people off the ship, because it was quite obvious that the mix was not the right people. Some of them were excess and some of them were not needed on the mission (I had too many legal people.) We needed rack space, and we knew that was going to be a limiting factor.

I know that for some of the NGOs that landed at the airport, it took them awhile to get to the ship. There were about 50 helicopters in theater, but there were a lot of things going on and we didn't control those assets. I was going up there every day going, "What's going on with the helicopters?"

It was just a menagerie of things going on. There were lots of ships in the harbor who were not part of that, but we used another ship as a landing pad to move patients on and off, because we could only get one helicopter aboard at a time. The NGOs came through Port-au-Prince, and I think they had to stay the night in the airport because there wasn't a way to get to the ship that night.

We were getting medical and other supplies. We also had contractors coming down and helping us with some of the things we had to order. The surgeons had identified what they needed to do all these cases. We had taken on hundreds of patients, but we couldn't do all the surgeries right away. Tom Olivero and Tim Donahue decided that if we got orthopedic surgeons (we got thirteen: ten from the Orthopedic Trauma Association, and three from Navy Medicine), they were going to work together in the ten ORs to reduce

this orthopedic load; but we needed the supplies, which was $5.5 million dollars worth, and that had to be sent here as well. It was fortuitous that the supplies, equipment, and orthopedic surgeons showed up at about the same time, and right away we started seeing 200 backlogged orthopedic trauma patients.

Q: How were the NGOs augmented into the system with the folks you already had? How did that work?

A: The ROS staff had already done that on a prior mission. They were junior people. These are not nurses or physicians. These are just corpsmen that work onboard the ship, but they were in tune with extending themselves to help people. When the NGOs came onboard, they needed to get to work, and they did get to work as quickly as possible.

Normally we have a very structured way to orient newcomers; they go through a ship's orientation. But some of the surgeons came aboard with their bags, and said, "Where do I put these?" They put them down and right away started to see the hundreds of patients they were going to do surgery on. We were in a mass casualty situation for ten to fourteen days. I won't call it chaos, because I don't like that word for what was going on, but it was very intense, and everyone was working. If you don't know what's going on it looks like a circus.

Medical people know what to do. An orthopedic surgeon from Charlotte, North Carolina came aboard who had 25 years of orthopedic surgery and helped write four or five textbooks -- he knows what he's looking for. All he needs to know is, "Where do I go? This is what I'm going to need. He turns to an ROS guy and says, "I need this, this, and this." Petty Officer Singer (identify?) jumps out of the shadows and says, "I'll get that for you. Give me a second." And the surgeon goes, "Wow, he knows what I'm talking about. All these other things are going on and I don't know what's happening here, but I know what I need to do." Those are the types of interactions that were occurring in a very positive way.

Q: When you arrived in Port-au-Prince, what did you see there in the harbor?

A: Every night we would have a meeting at 1900 with the staff. They were very anxious about what we were going to get involved with. We'd all seen the news reports; we were all trying to get up to speed on who each other was. The commodore was not aboard at that time; Captain Thomas Negus didn't arrive until the middle of day one.

The Army medical guy [MG Harold Timboe, USA, Ret.], and his deputy [COL Frederick Gerber, USA, Ret.] were here planning for Project HOPE. I had him in the meeting every morning, because my idea was to build on the relationships we had. They did a great job, and were very important for the success of the overall mission.

The real difficulty was people within the bureaucracy who got involved who didn't know how to work with the NGOs and slowed their processes down. That became problematic, because we needed rapid, flexible execution of what we needed to do, which we had done the first eight of ten days, and then all of a sudden layers of bureaucracy showed up. Now that's the military and that happens, but this was a medical mission. Maybe from the operational standpoint that was what needed to happen, and I was probably too far out there. But like I said, I was pushing and pushing and saying we can do better if we become more flexible and keep the transparency.

At 1900 on Thursday night, we were about 70 miles away from Port-au-Prince harbor, and the word came down that the *Carl Vinson* was steaming towards us, because they were crushed with patients. They were overfull in a mass casualty scenario, and they wanted to get people off the ship. They're a small medical department and when you get 50 people, some of whom were dying, they wanted to get those patients to our ship. So they called and said, "We've got patients for you."

We said, "We'll take them. You get them to us as quickly as you can." So 8:00 at night comes and they started coming this way. At nine o'clock, when we were are 20 miles away from the *Vinson*, we can take the first patients, because they can fly the helicopters to the ship and back (we were 50 miles out from the harbor). At 10:00 PM Bob Hawley and I go up and I'm thinking, when do you think those helicopters are going to get here? The message is, "We're launching them now. We're going to go get the patients."

I said, "It's 10:00 at night and I'm going to bed."

Bob said, "You're going to bed? The patients are going to be here."

I said, "You know what? The staff will figure it out. They know what they need to do." The sense of excitement on the ship wasn't anxiety anymore. It was, "We're here to help, we're here to help, we're here to help." It was just rampant, and in a very positive way, because they didn't know what they didn't know. I knew it was going to be trauma and sadness and other things which you would expect to see in a mass casualty, and I went to bed. I heard the helicopters coming and guess what? I slept like a baby. I got up the next morning at day break. I took my shower, put my uniform on, walked down, looked outside and there are 15 helicopters ready to land on our ship. I said, "How many patients did we take aboard last night."

Bob said, “We took two.”

I said, “Okay.”

He said, “Oh yes, everybody was down there.” I got a good night sleep, because I knew what Friday was going to be like. The problem was the rest of the staff was up all night, so the first day was a 40-hour day. That set them off cycle, because you need good sleep management.

We started that morning with helicopters landing every ten minutes. As they would land and take off, another one would land and take off. Some of them were Coast Guard; some of them were from other Navy ships. These weren’t helicopters from our ship because they hadn’t even gotten off the deck yet. Everybody was trying to land from the ships that had patients, but we didn’t know how they were going to get to us from the shore. People started moving boats with patients towards us; we had to discourage that because we weren’t taking any by boat, and that was problematic. That really did concern Bob Hawley before he set the anchor because we didn’t know how we were going to handle being assaulted from all angles with patients; we needed to control that.

So we started to gather information about helicopters from other Navy ships. The *Bataan* had been there for 30 hours; the *Vinson* had been there for about 72 hours, and they wanted to get their patients to us. It was not well orchestrated from the standpoint that there was so many aircraft in the air. We would take whatever we could take initially. At some point you have to have some type of control over who’s landing on your deck, but there were still many, many people dying. ?? I mean, people were coming aboard being bagged, so if the person who was bagging them stopped they’d be dead.?? *What does this mean??* [Bagging refers to the hand-operated ambu bag that forces air into a patient’s lungs. Artificial respiration so to speak] Everybody was moving towards the ship and we needed to gain some control over this.

Now, a normal mass casualty is for a day; my experience back in ’83 was a full day and a half of mass casualty. You know what? You get over it and then you move on. But this was a two-week episode of day-after-day-after–day-after-day. The coordination needed wasn’t there initially. There was nobody to coordinate it except us, but we needed knowledge about where the medical sites were on shore, and which patients needed to come to the ship.

That’s the reason we sent our two most skilled trauma surgeons ashore to do the triage, and that’s a very important point. I wouldn’t do it any other way now, because they could look at patients and determine whether their lives could be saved by coming to the ship,

or were too far gone, or were not severe enough to match the skill sets that we could use to save other patients. A civilian DART team that was there estimated that the first three days CAPT Stockinger was there he triaged over one thousand people. If you'd had a camera and were watching him you'd be asking, what's he doing? But he's a trauma surgeon; he's been to Afghanistan and Iraq, he has a sixth sense about these life and death decisions. Of the thousand people, he probably picked 150 to come to the *Comfort*. He was at one of three to four sites that we were taking patients from. Knowing how many patients I took, which was a little over 300 during those three days, he probably got half, or 150. So he saw one thousand patients; that one's not going to come, that one's going to come. He can give you the stories.

From my standpoint as CO of the hospital, my biggest responsibility was to the mission, which is to take care of the most people to do the most good; and to take care of my people, to make sure that the people that I work with are doing okay. That requires me to maximize the efficiencies of the hospital. How do I do the best by the hospital? Well, you start with the end in mind and you figure out a way to get patients off the ship. Unfortunately, that took us a while to figure out, as I talked about earlier.

The second thing is the staff on the ship; can they do their job efficiently and effectively -- and that requires the right supplies and the right team members. The third thing is do we have the right mix of personnel aboard? One of the things that we learned (Mark Marino [the Chief Nurse] will talk a little bit about it) is that for the safety of all these critical care patients, we needed more nurses. The problem was we didn't have enough bed space for my staff. We had tapped out the available bed space for staff on day six or seven, because we had filled it up with 1,200 medical staff, plus security staff, and the commodore's staff.

The commodore showed up the first day while we were in Port-au-Prince. He was flown in from the *Vinson*, and he had a staff of 35 onboard two helicopters. Then you had the security group of 76 people, and the 27 PAO people (eighteen civilian plus nine handlers from Navy Medicine). That is about 170 bodies, but we needed about 170 more staff onboard the ship to be at maximum efficiency. We didn't quite have that. Nobody knew that until we did this mission. If we'd had that full staff, we'd have full capability, and if we had 500 patients aboard, we could do 50 operations a day, moving 50 people on and off the ship every day; it's called throughput.

If we ever had to be called to do this in the future, that would be a piece of the puzzle. We got close to 85% to 90% efficiency, but we really didn't have quite enough nurses. Nursing care by day eight became problematic, because we had so many patients and the nurses were just tapped out. A surgeon can basically do a surgery and say, "I'm done,"

and do his rounds, but the nursing care was the most difficult piece of the mission. I had 153 nurses. It wasn't like I didn't have enough nurses in that regard, but you couldn't do everything for everybody all the time. That's called compassion fatigue when you demand that. The Navy didn't provide enough nurses, so you have to maximize what you have, and that's where the NGOs came to the table and helped us. They brought pediatric nurses. But guess what? We still didn't quite have enough. Thirty-five percent of our patient population were children, and we probably didn't have the proper mix of nursing care. We know that now for the future, and that's all been documented. We just didn't know at the time.

Q: Is that because of the triage process?

A: No. Everything seemed to mirror the population. If you look at how many children are under 14 in the country, it's about 30-35%. How many patients did we have onboard that were under 14? About 30-35%. Another example would be HIV, because that's big in Haiti. About 1.8 to 2% of the patients that we saw onboard had HIV. The World Health Organization says that's what they have in their country, so everything seemed to follow demographic lines.

One of the problems with the NGOs was a couple of the nurses that they sent were very young. They wanted to do a good job, but they were caught up in the moment. One of the Project HOPE nurses was very exaggerated in an email she sent out about all the things that had occurred, when in fact her knowledge base was fairly minimal. I think she was just talking to one of her friends, but her email said we didn't have enough pacifiers ? Pacifiers? . Yes, we didn't, but this was a mass casualty event day-after-day, and the scale of what is reasonable and routine is much different.

It's like coming to an auto accident involving ten people, and you're standing there going, "My God, what do I do?" But this happened every hour, every day. Medical people really do know what to do, even if it's very complex. I hope you get a chance to get to talk to Lieutenant Commander D'Aurora, who ran the casualty receiving emergency room, because his staff was one of the real success stories. Even though they didn't have all the different types of people they would have liked to have had, they had trained together. They felt very comfortable with each other, and were able to efficiently execute the mission of moving people in and out of the emergency room into the operating space, the wards, or the ICU, because they had a good team.

Q: Could you take us from the time a helicopter would land on the deck?

A: Chief Wood [HMC(SW/FMF) Brian A. Wood] was the person who would move people onto the ship while looking out for any problems. Whenever you have helicopters bringing patients you always want to make sure they're not bringing anything dangerous onboard. They would land on the flight deck. Litter bearers would move out to the helicopter, take the litters off, and bring them to the elevators. At that point we had a Haitian-American translator who would translate for the patients and the escorts (we had escorts with many of the patients) to determine what the issues were and to make them feel comfortable. They would get on the elevator to go down to the casualty receiving area where a triage center was set up.LCDR D'Aurora, Casualty Receiving Division Head, and LCDR Cooper, full name??, our emergency room doc, and some of the other doctors and nurses, would begin to identify what the patients had.

Once we got better organized we would know the types of patients who were coming to the ship on the helicopters, but early on, when the helicopters landed that would be the first time we would see them. Once they got to the emergency room we had 50 bays, and there were anywhere from 15 to 30 patients in that space on any given day. The doctors would come through and decide what the preliminary diagnosis was, whether they needed to go directly into surgery or whether they could wait; and what lab tests or radiology exams were needed. Some patients could remain in the emergency room for a couple of hours.

After day two we had ten operating rooms working full time. We would keep one in abeyance for military staff if they had an accident. The twelfth operating room was the angio suite; it wasn't being used because it was under repair.

After day four we stared to have movement both ways. Patients would be coming on the ship from helicopters and other patients would be leaving, because we needed to free up bed space.

The biggest difficulty was getting helicopters to come back to the ship after day seven, because they were being used for other logistics services in theater. We had to figure out a way to get patients off the ship, and we began to use boats if the tides were in our favor. That was problematic. Although we could do it, there was a higher risk involved because of the motion of boats when moving the patients.

Q: This was to take them off, not to put them on?

A: That's right. We had to take off hundreds of people, and some of them were paraplegics or weren't mobile.

On the ship there were two different things going on. One was the day-to-day activities internal to the ship; the XO ran that. The other was external medical operations, getting patients on and off the ship. These were two completely different processes. The two people who I looked to for how things were going on a day-to-day basis were the executive officer and Captain Andy Johnson, who did the medical operations. He and his staff were involved with the American embassy in trying to figure out how to do daily movements of patients.

We also had American fixed-wing assets coming into theater that could move patients back to America, and we got like 60 patients on that. But there were also people sending patients back to the States from other hospitals, so we obviously didn't see all the patients at the hospitals in Haiti. As I mentioned earlier, the University of Miami had a hospital set up at the airport, and there were others. That was all coordinated by the USAID point of contact at the American embassy.

Q: Did you maintain contact with USAID?

A: Oh yes, I had two doctors aboard who were from USAID. They were my advisors and were going back and forth bringing information. I also had three Project HOPE civilian advisors aboard who were who were trying to develop the NGO piece onshore.

Then I had CAPT Gallagher, who I'd identified on day five. "You've got to go over to the meetings on shore so that you can tell us what's going on." That was her job and she became very effective at finding where the NGOs were.

When we first got in-country we knew where the government medical systems were because that was what we dealt with on our last mission. I'd worked with the minister of health, who runs the healthcare system in country, and we knew the doctors in those seven hospitals, but they were overwhelmed with the number of patients within the 12-mile radius. Many of those hospital buildings had collapsed and were unsafe, and they had to bring the patients out into the parking lots in the open because we were having aftershocks. The first morning we were there, the pier collapsed that we were going to use as a boat landing. We felt it on the ship, and about every other day we had an aftershock that everybody on the ship felt. I felt really bad for the people on shore,

because that was a reminder of how tragic things had occurred and that things were still moving around in the Earth.

Q: What range of injuries were you seeing?

A: They were generally crushing injuries. The neurosurgeons and the neurologist were very busy with neurological injuries--head trauma, spinal cord injuries. The thing that caught a lot of people's attention were the babies that were being born to mothers who were injured, and some of them were preemies. We weren't bringing mothers aboard just because they were pregnant; the mothers had all been injured.

The other thing that we had to deal with was that some chronic patients were getting to the ship who weren't injured in the earthquake, but once a patient got onboard, the doctor was going to treat them like they were one of their own family members. We were directed to see only earthquake victims, but if they got to us, even though they weren't the right type of patient, we were going to do what we could do to help them.

That's the psyche and temperament of nurses, and you can't break that. I'm a hospital administrator, and I never wanted to get involved with giving medical care. Somehow a hydrocephalic baby got here, but once it got into the hospital we didn't send it back until it was healthy enough to get to a place that could take it. Every time I took the bigwigs down to the pediatric area, I saw that child and thought, "That child's not supposed to be here, but I really don't care. It's here, and we're going to take care of it." I never really ventured towards it, but the four stars [admirals] could see it wasn't one of the earthquake victims.

About seven percent of the patients that we got were chronic patients; they weren't casualties from the earthquake. We would make the point that we don't want to bring chronic patients to the ship; we wanted earthquake victims. That's the reason why we were there, so we had to have an exit strategy for the ship. The exit strategy, which was very hard for the staff to understand, was we wanted to build medical support on the ground. "We can still see patients onboard the ship, but if we see patients that are chronic, we're not developing those skill sets on shore." We talked about this a lot with the staff, but they didn't really hear it. We wanted to build a medical support on the ground in Haiti to be equal or better to what they had before the earthquake.

The American government, along with many other governments and private organizations, were giving things to Haiti, and that was very good. Haitians who were not

injured were receiving better medical care by the time we left than they had been receiving before the earthquake. There were so many medical people from all over the globe who'd come to the country and were providing services, and that was the intent of Alex Larsen, the Minister of Health. He came out to the ship, saw what we were doing, and thanked us; but he also said, "*Comfort*, you can go home now. We appreciate your help; we thank you very much. The people of Haiti are happy that you came, but we're going to take it from here and we appreciate what you've done." That was the signal that allowed the president of Haiti to tell President Obama that we could go home on the 10th of March. We all expected that might be the date, but we weren't sure, and not even the Joint Chiefs of Staff Admiral [Michael] Mullen could tell us three or four days before. We did not know we were going to leave until the 9th of March. [The *Comfort* departed on 10 March.]

The idea was that we couldn't do everything for everybody, but we could help them grow their system. We would send our doctors on shore not only to follow up over 550 patients we had sent to the NGOs, but also to do some consulting, with the idea that we weren't going to get embedded into their system.

In addition, USAID had picked up the ball and was running with it to help build the healthcare infrastructure, as well as PAHO, the Pan-American Health Organization, and WHO, the World Health Organization. By day 35 the real focus was on rubble removal and shelter, not medical care. Haiti had built up its medical care for chronic patients to a higher level. As for acute earthquake victims, there weren't any at that point that we could have seen on the *Comfort* that couldn't be seen on the ground. Those were political issues that I really shouldn't get too involved with or speak about. But I did understand, after being told many times, what my mission was. Does that make sense?

Q: Yes.

A: I mean, that's an esoteric point, but it's very important to understand because hypothetically people could say, "Well, the ship didn't do all it could do." Well, we did all we could do for the earthquake victims and we also tried to be supportive without getting too involved with support that might come their way if we weren't there. We were not taking acute emergency victims who had been in an auto accident. Our focus was on the earthquake victims. It's a moral and ethical issue. All I knew was I was given a set of guidelines, and the types of patients that should get to the ship needed to be those types. Once they got here, I didn't care what the doctors did. I wanted them to take care of them just like my family. I just ignored that rule because it was the right thing to do for the patients. But I wasn't going to put them on a helicopter to bring them here and break the rules.

Q: Briefly, can you say something about your meeting the first time with the minister of health? Your mission, obviously, had been briefed to you, so did you go to meet with him as soon as you arrived in port?

A: I did not, because there were higher levels of organization that were in place. The ambassador and the JTF commander and his staff were there (although the medical component of his staff was very small).[deleted *immature* -- wrong word]. I went ashore on the second or third day, the 22nd or 23rd, to find out what was going on and to help in any way that I could. When I got ashore I realized there were U.S. military people there in the medical planning section. Of course, they had been doing God's work, but there weren't enough of them. One officer there was Michelle Hancock, a commander in the United States Navy, who was flown in from Southern Command within two days after the earthquake. She did an incredible job, but by day nine or ten she was exhausted, She was one of about three or four people in the medical cell. Another one was an Army colonel; he'd only been there about 24 hours; they delete *they were immature* -- wrong word]; didn't have enough people.

I had been told not to go ashore, but we were so blind that I felt I needed to in order to find out what was going on.
BUMED was not happy with me going ashore. In fact, I was directed not to by one of my colleagues at BUMED, but I don't think he understood that we had to get people off the ship, because we were going to fill up and not be able to see any more than 500.

When I got to the American Embassy I wanted to sit in the back of the room of this large group of people, but they brought me to the table in the front. Of course, they went around and introduced themselves, but I wasn't looking to grandstand. I really wanted knowledge, and it was a very uncomfortable situation when everyone looked at me and asked, "What's going on?"

I was like, "I was hoping you could tell me about the hospitals? And how's Dr. Larsen?" The only thing I really got from that conversation, which never panned out, was they had identified somebody to go around to all the medical facilities to determine whether they were safe to put patients. That report never came, and my staff had to go out and do that work.

All I could say was, "If the minister of health wants to come out to the ship, we're available." But you know what? He was living in a tent, and he had lost family members. What we were doing was great and he was happy to have us, but it wasn't his main focus and I can understand that. We were just part of a much bigger picture for his country.

He did come out to the ship later. One of the corpsman onboard was his nephew whose dad was the head of the military police in Haiti. ???And his dad was a physician. ???? *This doesn't make sense*. We had a lot of Haitian Americans onboard. We had 66 Navy translators onboard; the Navy did a great job at getting people that spoke Haitian, and these corpsmen had a special relationship.

Having the minister of health come aboard was not a priority for anyone, necessarily, although we were there to support the Ministry of Health. I could speak on his behalf, because I knew him from prior Continuing Promise missions. I spent three days with him in December of 2008, and I was with him and his staff for 12 days in April 2009 when his staff came to the ship to see patients, which was good. We knew Dr. Fontaine [Nicolette Fontaine, M.D. – which NGO?? – Project Medishare??] and other doctors.

Dr. Larsen came out to the ship at the end of the mission in Haiti to thank us. That was a very emotional moment. We lined up all the translators; they were all Haitian American Navy guys. As these diplomats often are, initially they're very formal, but by the end of the visit he was swallowed up by all the Haitian American people in uniforms like mine, and he could sense they were his countrymen too. It was just one of those wonderful moments. He truly was there to say thank you. He said words could not express his appreciation.

When he walked down the hallway of the second deck he came to a picture on the wall of him and the Prime Minister a year earlier. I was standing right outside that picture when they took it. What was sad is the shirt that he had on in that picture was the same shirt that he had on that day. I believe he didn't have many shirts left because he was living in a tent after the earthquake, as was the president and prime minister.

Q: Last time you mentioned some of the patients that stand out in your mind. Tell us about those.

A: You ought to look up Steve Sternberg's articles in *USA Today*. We talked about Baby Isabelle and the artist, Hughes LaRose; hopefully he's going to do very well. I mentioned the hydrocephalic child, who became a fixture in the pediatric ward. Another child that came aboard, interestingly enough, was one that Sanjay Gupta, a neurosurgeon, had seen in one of the camps and was brought to us for follow-up. He came aboard to see the patient -- in my mind somewhat of a press opportunity for him -- but anyway, he's a doctor and we allowed him that access. I think he ended up doing surgery on the *Bataan [he performed surgery on the Vinson],* but he didn't work on the *Comfort* under my credentials.

There were hundreds and hundreds of patients. I think of those who were amputees. There was anywhere from 4,000 to 5,000 amputees. We did 37 amputations on board, and they tried every conceivable way to save the limbs. We did over 650 limb-saving surgeries, and those limbs would not have been saved -- at least the function would not have been saved -- in-country. The amputees were a sad situation.
There were two boys between the ages of seven and eleven in the pediatric area, and both were in wheelchairs (one of them had an amputation of a hand and a leg). After four or five days they were quite comfortable down there and the staff loved them. They'd do wheelchair races, one kid with an arm that was bandaged because he'd lost his hand.

The four-star, Admiral Harvey, who ran Fleet Forces Command as one of the three senior people in the Navy, came aboard, and thanked the crew for the incredible job they had done, but was still in a very firm, authoritarian mode. By the time he got down to that ward he felt the emotion that was appropriate, that the staff had done a very good job of helping each individual patient. He saw patients who had amputations, people who had bandages on their head, mothers and escorts. These were people who were happy to be alive, happy to be on the ship, and happy to be treated by the Americans and NGOs. But it was also sadness, because you could see that some of these people were going to have a long road to recovery.

When he passed those two boys, he truly did not have words to express how he felt. (I'm speaking for a four-star admiral, so I'll take a deep breath.) All he could do was take two challenge coins out of his pocket and put them in those boys' hands. His staff was moving him along; you know what it's like when you've got senior people being moved around on a schedule. He wanted to stop for a moment, take a deep breath and share with them the four-star coins that are sought after by everybody in the Navy. He gave one to each of those boys. They didn't know what to do with it, but knew it was like gold. As his staff was trying to herd us onto the elevator, he looked at me and you know that he had that moment of compassion.

He later wrote me a very nice, handwritten, two-page letter that I'm very proud of. It was to me and my staff to say, "Thank you for letting me come to the ship." The compassion in that letter said much more than just a four-star letter to some medical captain. What he felt and saw changed his life. And he wasn't the only one. RADM [Mark] Buzby from MSC was the same way when he saw how we helped the patients and that what we brought to Haiti as individuals, humanitarians, Navy, Project HOPE, or other people, was quantifiable, real, and will last a lifetime for the people of Haiti.

Our humanitarian mission was the right thing to do. People can talk about how we need healthcare in our country and why do we go down there? Why do we spend $17 million

to do this? People may be critical, but it was the right thing to do. They needed our help, and they probably still need our help. I think this ship will be back in Haiti. I think this ship still has services it can provide to the Haitian people.

Q: Thank you.

END 17 MAY 2010 INTERVIEW SESSION

BEGIN 21 JUNE 2011 INTERVIEW

Interviewers: Mr. Jan K. Herman, Senior Historian, BUMED; Mr. André B. Sobocinski, Deputy Historian, BUMED; Commander Karen Stokes, Dental Corps, BUMED, U.S. Navy

As the Cold War neared its inevitable end in the 1980s, a glimmer of a newer, more destructive conflict flickered in the Middle East. From 1982 to 1984, as turmoil reigned in Beirut, Lebanon during a bitter civil war, the U.S. Navy-Marine Corps team served as part of a small multi-national force trying to mitigate the carnage. On 6:20 a.m. on 23 October 1983, the Marine Corps Barracks at the Beirut International Airport, housing American and French servicemen, was targeted by two truck bombs. The resulting blasts killed 299 American and French military personnel, including 220 Marines and eighteen Navy personnel (of whom fifteen were hospital corpsmen and one Navy physician). Immediately following the attack, LT (later CAPT) James J. Ware was one of two Navy dentists attached to the 24th Marine Amphibious Unit (MAU), who went into action mustering personnel to provide emergency medical assistance.

LT Ware simultaneously set up a battalion aid station and, assisted by ten hospital corpsmen and two dental technicians, performed initial triage, tagged and identified patients, started intravenous procedures, and provided other emergency care. Ware and fellow dentist LT (later CAPT) Gilbert Bigelow provided treatment for 65 casualties in the first two hours following the explosion, and prepared their patients for evacuation from the aid station to ships offshore for further medical treatment. In this oral history, CAPT Ware recounts these harrowing experiences.

Q: Please identify yourself.

A: Captain James Ware, United States Navy Dental Corps. I was commissioned in 1982 as a Navy lieutenant right out of dental school. My first assignment was with the Marine Corps at Camp Lejeune, North Carolina, with the 2nd Dental Battalion. I had a good six months of initial indoctrination into the Navy Dental Corps, basically providing services in general dentistry, oral surgery, endodontics, which takes you through a cross-section of areas to get you prepared to be deployed with the United States Marines. Our commanding officer had a list of people who would be deployed with the MAUs, which would usually mean Camp Lejeune or Cherry Point, North Carolina; or military operations in the Mediterranean. The Marines would always take at least one, sometimes two dentists.

Q: And that's a Marine Expeditionary Unit?

A: Marine Expeditionary Unit, at that time it was called a MAU, Marine Amphibious Unit; they changed the name later. At Christmas time 1982, one of the dental officers did not want to go, so they took a show of hands of who would like to go. After consulting with my wife we decided that it would be a good time to go early in my career to Camp Lejeune so we could start a family afterwards.

So in May of 1983, after I had been about four and a half months with the 1st Battalion, Eighth Marines and the 24th MAU, there was a preparatory period for newly assigned people. We would do dental examinations and make sure they had all their charts and their X-rays -- specifically their panorexes and bite-wings for identification purposes. I thought this would be important, because there was a lot of helo operations that we planned to do. There were already two Marine units that had been to Lebanon. During that time the Syrians and Israelis had confrontations around southern Lebanon, and to oversee peacekeeping in the area, United States Marines, along with French, British, and Italian forces, were deployed to Beirut in August 1982.

When we left Moorehead City, North Carolina in May 1983, our mission was that we would protect the Beirut International Airport and ensure that we kept the airport open, because as long as the airport was closed it was a country that was closed off from the outside world. The Marines were also a buffer between the Israelis and the Syrians, while trying to help the Lebanese get back on their feet.

The MAU had two dentists, myself and Lieutenant Gil Bigelow, who I consider a very close friend. Gil is still down in Virginia Beach; he practices dentistry there. He was the senior dentist, and we shared responsibilities as partners. We've often been called the "Dynamic Duo" or sometimes "Butch Cassidy and the Sundance Kid." Gil was responsible for the helicopter squadron; I had the grunt battalion, the 1/8. We were providing services for those two groups; he'd come from Cherry Point; I'd come from Camp Lejeune.

We arrived in Beirut on the 28 May 1983. Things there were interesting, because about two months before there had been a bombing at the American Embassy where sixty people were killed. We were on a heightened state of alert, and when we got to the airport we set up our perimeter. There was one physician with the group who kind of bounced around there. His name was LT John Hudson. He and a Marine intelligence officer and Navy Lieutenant Jim Surch served as my roommates coming over on the USS *Austin* (LPD-4).

John Hudson, by the way, was killed during the bombing. I considered him a close friend at the time, and I think he did some things for both Gil and me that resonated and probably saved lives. He brought us into the medical planning early, and he made us equal partners in our understanding of what our responsibilities were, even as junior medical types. Most dentists don't really think of themselves as part of that extended

team in a mass casualty situation. We get trained for it, but most of us hope that we will never be exposed to those types of issues; yet sometimes we are.

The first two months in country were fairly subdued. An occasional mortar round would come in. There would be some return fire from across the base. We would be in lockdown for a period of a few hours, and then we would be allowed to move freely around the compound.

Q: Could you describe the compound?

A: The compound housed many different groups, but it looked more like a four-story hotel or a business office. To the west of the compound you could see the Mediterranean Ocean; to the east you could see the Al Shouf Mountains of Lebanon; to the north you could see Beirut City, and to the south you could see the open area that extended to Israel. In addition to the compound we had Marine companies stationed in two other buildings around the airport. One was the headquarters building, which was a small one-story structure, which is where Colonel Tim Geraghty and his staff of 40 or 50 people were, and I was in the third building, which served as the Marine Service Support Group (MSSG) headquarters. In our building there were probably about 100 people; in comparison, the compound housed about 350-360 people. Some of those people lived outside of the building, but most of those people were in the building when it was attacked.

LT Hudson and his group of 21 corpsman were stationed in the compound. They could have put the dentists in that building as well, because it was large enough to accommodate us. Of the corpsmen that were with John, I think seventeen of those died in the blast and four or five were wounded; and John died as well.

As things developed on the ground it became obvious that we went from serving as peacekeepers to a group that was really "hunkered down", as Colonel Geraghty would say. His main ambition was to leave the airport, because we were always on the defensive. I think he was hoping that we would move further south because we were indefensible. Artillery rounds were easily thrown into our area as well as small arms fire. From a medical perspective, when we had patients, we had established a routine where John Hudson would take the first five, and we would take the next five or "overflow" at our building.

As things heated up between August and September, we had 60 wounded and eight killed in action out of 800 people on the ground. When you only have about 800 people on the ground, that's a lot of people; that's one in a hundred killed, and these are guys that you knew.

Q: You're not peacekeepers anymore at this point.

A: That's right. But you know what happens in combat. You get more and more acclimated to what's going on around you. You're fearful, but you become almost callous to what's going on, even though they're picking people off. If you go for a couple of days without

anybody getting hurt or any small arms fire hitting anyone, you kind of feel like, "Okay, we're getting used to it. We're getting better at it." That's the way you develop your blind spots in combat, and I think this is what happens with the real war fighters.

On 23 September our building received a direct hit from a mortar. I remember it was seven at night, the sun hadn't set yet. I was licking an envelope and putting a stamp on it to send to my wife. That was my first experience with concussion injury, a concussion where you can't hear anything, along with the smoke, the ringing in the ears, and the confusion that occurs in such a situation. We had four injured that day. I wasn't one of the ones injured, but we really got the experience of how to respond. We did very well. We didn't lose any lives and I don't think we lost any fingers, limbs, or any eyesight, but we had four individuals who were pretty well ripped up from shrapnel.

Q: Were they medevaced to the ship?
A: They could have been medevaced to the ship, but they were all brought to our area. Of course you learn when you put a Battalion Aid Station (BAS) in a basement that injured people can walk down there pretty well initially, but once they've been treated, you've got to carry them back up on stretchers and now they've got IVs in them. That was a real learning experience. I remember, "The HELO's here, let's take them up there." We learned not to take people down into the basement again.

Q: There was an LPH off shore?
A: Yes, the USS *Iwo Jima* (LPH-2). It was the old one and the the *Austin* was there was well. The first or second week in October things seemed to change. It was almost like autumn was coming, because the days seemed shorter and not as hot, and there was a change in the air in a positive way. We went for five or six days without any negative interaction, and we figured we must be doing something right. This leads up to the morning of the bombing on 23 October. Believe it or not, we actually had a band come ashore the day before for a kind of USO "get-together." I didn't see it myself, but they were over at the BLT building. They performed a little concert and then were flown back to the ship on the night before the bombing.

The bombing stopped the clock on the wall at 6:21 AM October 23rd. A truck came in with 15,000 pounds of enhanced TNT. [Correction: The Long Commission cited it as *the equivalent of 12,000 pounds of TNT.]* When it detonated it was the largest moving non-nuclear explosion up to that point. Source? Suggest replace this with: *It was described as the single deadliest attack on Americans overseas since WWII.*
The driver, obviously, died. The idea was to sneak into the airport parking lot and do three turns of the truck where fruits and vegetables and other things would have been delivered every day by a similar truck. I would call it a 5-ton Mercedes Benz truck. The fact that he was going around in circles in the parking lot would normally not cause suspicion. Even though it was Sunday, those types of trucks were always there bringing different things. When he had enough speed he came at the guard who had 10 to 15 seconds to make a decision; the truck passed him and was able to go straight into the building. When the explosion went off it brought the whole building down. There were

350 to 360 people in the building, and they were all killed or wounded. Some of them weren't actually physically wounded, but they were completely deafened. Some of the first patients I saw that morning were all deaf and covered completely in ash and silt.

Q: Obviously you heard the sound?

A: Yes. Gil and I and two Marines were in bed. We were 250-300 yards away from the center of that building, and I could feel the reverberation of the explosion. When the explosion occurred, it bounced off the walls and anybody in the building would have percussion injuries. I don't know a lot about percussion injuries, except that when they happen underwater it's much, much worse.

But I remember feeling the percussion. In fact, when it went off, Gil is sleeping and I jump up and go, "God, what was that?" We weren't scared. We were, "Oh, here we go again. Get your stuff." Gil went one way to the BAS and I went the other way. Our door had been knocked off its hinges; I stopped, pulled my camera out of my pocket and took a picture. I'm really trying to describe to you that I had no idea that what had just happened was so devastating. I just thought it was another direct hit; we'd already had one direct hit on the compound, so I was just trying to chronicle what I was living through.

My focus in running the BAS was to make sure that everybody was prepared. We had assigned drivers and medics to jeeps to go out to the different areas to pick up casualties from sniper or small arms fire. I asked. "Is anybody hurt in the building?" The answer was, "No. Does anybody know what's going on?"

I asked the communications guy, "What's the walking-talkie saying? What's the headquarters saying?" What's going on? Can we go back to sleep?" (It's Sunday morning, and you can sleep in late.) These are the thoughts that I'm having, like, "This is a pain in our ass." But the first thing was, we don't have any communication with the BLT and we don't have any communication with the headquarters, because we're down in that cellar that I've talked about.

At some point, Gil comes back from his BAS and he says, "We think the BLT's been hit."

I said, "What is going on there?"

He says, "I don't know."

"Have you talked to John Hudson?"

He said, "No, but I'm going to ride over there with the MSSG commander." Gil gets in the Jeep and rides over there. He sees the building and turns ashen, because the building which was standing yesterday is now a pile of rubble. He turns around and comes right back to me.

I'm downstairs opening up some peanut butter and putting it on a cracker to have breakfast, and he comes back, obviously emotionally changed. In a quivering voice he goes, "Jim, prepare for mass casualties." Gil is probably the most experienced guy who's there; he had been an Air Force reconnaissance guy in Vietnam. He was probably 28, or 29. He was older, had seen combat and knew a little bit about what the issues could be if they got bad. When he told me, "Jim, prepare for mass casualties," I figured John Hudson was going to have a lot of patients. I said, "Great. I'll set things up here. I'll be in the back of the building. Just start sending them over."

After a few minutes I'm still wondering what's going on; remember, he didn't tell me what happened. He just said, "Prepare for mass casualties." The first patients that show up are walking wounded, covered in silt, and could either walk or be helped to walk over to where we were. There were patients who were on the top of the building, and when the explosion occurred, miraculously rolled off the building as it came tumbling down.

I can remember seeing a lance corporal who was totally deaf. I said, "Are you okay?" He says, "I don't know what happened. All I know is the building started to move and I began to roll and roll and roll and roll." He's deaf now so he doesn't know how loud he's talking, and then he goes, "You've got to help those people. You've got to help those people." I mean, this was a nightmare. He's talking very loud but he can't hear us talking because his ears are ringing at a very loud level. He was literally on the roof as the building went down, and he survived.

The next guy was Lance Corporal Matthews and he later played football at the University of Maryland. [Delete: cannot confirm this -- Matthews was in the USMC 1981-2005, and retired as a MSgt]. He was in shorts, a big, muscular guy with scratches all over. He was blinking because he had so much ash on him. He said he was on the second floor and was blown out of the building. He was the second or third patient, and I'm going, "Wow, I wonder what John Hudson's seeing? I wonder what Gil's doing?" Then the first truckload of patients came around. These patients had been thrown into the back of a truck and driven to us, and now I am beginning to see people who had limbs mangled really bad.

It's been eight to ten minutes since Gil said, "Prepare for mass casualties," and now we've got eight people we're taking care of. I'm thinking, "Where are the helicopters? When are they going to get here? Where's the communication?" But all communications are down.

It was about an hour after the explosion before the first helicopters got there that the patients got on. The number of patients we had at our BAS went from eight to between 80 and 90, but we only medevaced 63. They were the worst of the worst, the ones who were really wounded and needed to be medevaced.

I had sectioned out four areas of medical care at my site to identify the most critical people who were going to be put on the helicopter. I had immediate care, delayed care, expectant, and the dead. The expectant group I had was fairly small, but there were some of those that would come through. There were a few individuals who really were not going to survive, and so they were not the first on the helicopter. I remember First Sergeant David Battle was a very senior guy in that group. His injuries were quite significant: a lot of burn injuries, as well as tearing of one of the upper shoulders and arms. The four groups really changed as the morning went on. What looked to be bad initially was good about a half hour later when we saw the worst patients who came through the site.

I jumped around a great deal. Our biggest problem was communication. We had to rely upon runners. I'd send somebody to the site where the helicopters were landing and I'd ask, "How many can we put on the helicopter?" or "How many is John Hudson sending?" or "Gil, how many are they sending?" At the time I didn't realize John was dead. I thought he and Gil were working together and I was taking their overflow. When you get to 60, 70 patients and many of them are really critically wounded, you're thinking, "Man, they must really have a problem there." It wasn't for a number of hours when no one had seen John Hudson that we realized he was probably dead in the building. As it ended up, 241 American servicemen were killed either in the building or from their injuries.

Q: Where was LT Bigelow?
A: When Gil arrived at the site, he recognized that there was nobody to help pull people out, and he began to marshal??? the external area with corpsmen and to use morphine judiciously for people who were trapped. Gil was trying to organize the few people that we had available to extract casualties. His function was to give them "hands-on" first aid, and then to get them back to the BAS where I was. From there they would get on the helicopter.

Q: Were the two ships off shore sending the helicopters?
A: That's right.

Q: Who were the first people on the scene after the attack?
A: We had a small group of Marines who were available to help with the extraction of the 300 people who were in the building; 241 who were killed, and groups of Marines around the airport were being shot at. To this day I don't believe it was coordinated, but for whatever reason, as soon as the building went up and the smoke went up in the air they began to receive live fire and were held in position. We were being held in position because you can hear live fire; you don't have to be right next to it to realize that somebody's shooting at you. The next thing we knew was somebody said it was a car bomb and there's another car outside of our building. Well, I'm the senior guy and I remember saying, "We've got to get these guys over here because there's a car bomb out there," not knowing what the building looked like yet.

Q: How far into this was it when you were finally aware that the building was gone?

A: I'm going to get to that question. [See page 110]

I want to say the ships lost communication with the BLT and the headquarters, and the headquarters communications were down as well. They flew in the first helicopter after twenty to thirty minutes to get a look around and it went back to the ship to report to the commander; and he goes, "Okay, let's get people in there." They go to the first landing site but they can't land because it's filled with debris, so then they go to the second landing site, which is where we ultimately did our triage and our MEDEVACs.

The first people that came to help me were sailors off the ship. They had seen the wounded coming to the ship that morning, and they'd seen the wounded coming to the ship over the last six weeks. They had seen the gunfire at night in the hills, and they were scared. I mean, everybody's going to be scared, but there's a sense of acclimation in a combat scenario when you lose cognition of what's going on around you because you've become acclimated to the environment. These sailors didn't have that, so when they got to our site, they were not as useful as somebody who'd already been in-country, but I'm not saying that negatively. One was a physician, and some were corpsmen.

There was one individual, a dental technician named Paul Dziadon, who stood out; he was a second class and I know he worked here at BUMED for a number of years. He was the bravest guy that I saw. He asked me, "Lieutenant, what do you need me to do?" I said, "I've got to get the dental records out so we've got some identification." He crawled down into the debris to get the dental records in the basement where they were being stored. They weren't in our building; they were in the BLT, so Paul went there and identified where they were, because he knew instinctively that was important. He was a hero. He probably never received credit for how brave and courageous and selfless he was. I saw a lot of other people who didn't have the ability to do what he did, but I don't blame them. I saw Navy physicians who did nothing but try to protect themselves.

Q: What kind of helos were they sending in?

A: The CH-46s, which Marines have in the MAUs. Once we started to move patients, my fear was they wouldn't move them quick enough, but they were able to get the patients off the ground and to the ships very, very quickly. My problem was I didn't have communication at the site to find out what was going on except for the runners. The helos moved about 63 patients that morning, and another 27 patients went to local hospitals. Then we started to have other groups of people come to help us, like the Lebanese and the International Red Cross, which we let into the area around the building. Gil was there as the senior guy, but it wasn't organized. It wasn't even unorganized chaos. It was just chaos.

I've got this great picture that shows the last guy being pulled out of the building. He was an African American. He's on a stretcher and he's looking at you with a big, round face and all you can see above him are feet. When you blow up the picture, there are seven or eight Lebanese around him and they're working him out of the building. All you can see are these feet up here. They're all Marines and they're just watching. The Lebanese saved

this guy's life. They went into that building because they were used to that type of destruction in their city, and they had no qualms about doing it. They were there to help us. But when I give the psychological lecture for medical personnel I tell them, "Sometimes you've got to tell people what to do because they don't know what to do."

Many people came from the ship to help, but many of them had to turn around and go back because they were a detriment to the cause. I don't want to be negative, but there's that acclimation piece. They just didn't know what was going on around them. Whereas, there was a Lebanese Army base that was close to where we were and they rushed over to help us. These were kids that really didn't have any military experience, but they were very used to these bombed out buildings because from 1975 to 1990, Lebanon had an incredible civil war.

As we moved on into the morning, Gil comes back, and he looks around and goes, "What's going on here?"

I said, "How many patients do you have over there?"

He says, "We don't have any more patients. Everybody's here."

I said, "Oh, okay." I said, "Where's John?"

He says, "We haven't found John. He must have been in the building."

I said, "Well, how many people were hurt?"

And he responds, "Everybody."

I'm thinking, "I've got sixty people here that need to be medevaced, and another twenty I'm holding onto so Gil and John can decide who's going to go to the ship."

Q: You're under ground; you can't see anything?
A: I'm not underground. We moved the medical facility up to ground level.

Q: But you haven't seen the building?
A: No, I haven't seen it.

Q: You're just getting little pieces of information and nothing is making sense?
A: That's right. My reality was that it must have been a pretty good-sized bomb, but the gallows humor thing is still in my thoughts, I mean, that's how people deal with it when you're in a combat zone. I mean, I've seen people dying, people expectant, but there is a gallows humor.

One of the things I remember (and every year I give money to the International Red Cross because of it) was an International Red Cross doctor. He was a tall Caucasian in a

white coat, probably in his mid-60s, walking up to me with a bag. He hands it to me, and in what I guessed was a Swiss accent, says, "This is for your patients." It was squeeze tubes of French morphine. The International Red Cross doesn't like to crossover??? with the military, but he walked over and gave that to me. I didn't need it, but that was a gesture of kindness. It ended up being a burden to me because I had to lock it up and carry it around. Nobody would take it when I got back to Camp Lejeune, so I had all these drugs that I was responsible for. When you're in the medical community that's a big deal, and nobody would take them.

I think if you talk to Gil you should get his take on this: I think there were some people trapped in that building that Gil gave the okay to corpsmen to go in there and make them comfortable, because they were screaming. Those are personal decisions, but there were people trapped.

I walked over to the building about 11:30 that morning, and that's when I first saw it. They were still digging out two or three people. I had already moved out sixty people to the ship and we had kept twenty.

I told my team, "I've got to go over there and figure out what's going on." Of course, when I saw the building, it was unimaginable. You've seen the pictures. Even with the patients that I had seen, it was still unimaginable. Then the question was if Hudson was at one of the local hospitals, because a lot of individuals were taken there by ambulances, but we didn't know who they were. The other thing that occurred to us is the French building was blown up and they were taken to local hospitals as well. By the time they'd cut all the clothes off of the patients in the local hospitals, without IDs we didn't know whether they were French or American.

My dental tech, Richard Fly, went into the city to go around and find out if any of those patients were ours. I was very uncomfortable about that because I didn't want to put Richard Fly into harm's way, but the International Red Cross said, "We will take you to the hospitals we took your patients to, but you cannot bring a gun." I'm like, "Well, I don't want my dental tech to go. How would I explain it to Admiral [Richard] Shaffer if he got killed?" There were eight corpsmen, and they were exhausted, all of them, including Richard Fly. I asked, "Who would be willing to go out and get the names and injuries of the people that are at the local hospitals?" This was at about 2:30 or 3:00 in the afternoon. Richard Fly, who was a very meek and mild man, raised his hand. He went to every hospital and brought the names back. You can't believe how important that was, and how the colonel and probably the White House and everybody else was waiting on that information.

Q: So after you saw the building, you had done all the treatment you could do at that point, and everybody had been medevaced back to the ship?

A: That's right, except for about twenty patients I was holding because they weren't seriously wounded. They finally were taken to the ship for medical review, but that didn't happen during the first five or six hours.

Q: When did you find out about John Hudson?
A: Can I share two stories and I'll come back to that one?

There was one telephone line that came into the airport and then over to our building so that supply people could call out. You had to get a switchboard operator to pass it through from the airport tower. Now, the airport tower was about 400 or 500 hundred yards away; they should have seen the explosion for sure, but they didn't. There were still people in the tower. At about 12:00 pm I had gone to the site, looked around, figured out that there were no more patients there, and gone back to our building. I'm sitting there going, "Well, I guess we can hold these guys [the twenty less seriously wounded patients]."

Somebody runs up and goes, "Lieutenant Ware, you've got a telephone call." I'm thinking, "It's the president." I mean, I've just seen something, but I don't know what has happened. The building is down; I can't find my buddy John Hudson. These people are dying and this is a mess. Colonel Geraghty's walking around with his head down; he's patting me and Gil on the back going, "You did a great job; you did a great job." I'm thinking, "There's got to be somebody who wants to know about the medical situation."

I walk down the hallway; there are two different levels. I take a right, and walk down to this office; there's a phone in the back for the supply people. I pick up the phone, "Hello, this is Lieutenant Ware."

"Jimmy? This is Francie."

"Hey, Francie, how you doing?"

She says, "How you doing?" I said, "Honey, I'm doing fine. I'm doing very well. I want you to do one thing for me. I want you to look at what time it is, and I want you to call Gil's wife and tell her that he's okay too. I love you; I can't talk now. I've got to go. Just call Gil's wife and tell her that he's okay too. Bye, I love you."

I hung up the phone. My wife would get up at six in the morning on Sunday and call me on this line. Well, I'd forgotten it was Sunday; I couldn't figure out what day of the week it was. She had just been to a Georgia football game the day before, so she probably rolled over and closed her eyes, because my conversation with her was strange. "Okay, I can't talk to him. Obviously something was going on at work and he couldn't talk."

Some time later, her mother comes in and says, "Francie, there's been a tragedy; something's happened." This was when CNN started to have international coverage. They had film clips and they're showing them on CNN. Francie's mom and dad sat around saying, "Should we wake her up or should we let her sleep? What should we do? Jimmy's over there? He could be involved in this." So they got Francie up, and she goes, "You know, I called him this morning, I just talked to him." They figured out that the

bombing occurred ten hours ago. She had just talked to me four hours ago, so he's alive. Very soon after that all communications were down for seven days. We went to "River City", because people had started calling about their loved ones.

Q: When did you finally learn about John Hudson?

Q: Probably soon after that phone call. One of my jobs was to determine who was in the building, because no one knew. All the records for who was in the building were in the building. It sounds simple, but it was like the Pentagon; how do you know who was in it if this building goes down?

Colonel Geraghty goes, "Well, we've got to have some records. I mean, this is crazy. Don't we have records?"

I go, "I've got all the dental information. I know everybody who's here, because I'm a dentist and I'm fanatical about it if they come here." I wanted bite wings and panos [panorex], because I'd been worried about people going down in helicopters and I wanted to be able to identify them. So I'm pretty sure that my roster is 100% accurate-well, probably 99.8%.

He said, "Okay, you're the guy. You figure out who's in the building."

Well, you know how hard that was. Everybody up to the Secretary of Defense wants to know who's in the building. Well, it takes time. Who's in the hospitals? Who's on the ship? Who was in the building? Who transferred a week ago? All those things sound easy, but to connect them became very difficult. Then you've got the three Marine companies.

For the next four days we're pulling bodies out of the building and sending them off. Sadly, a lot of the bodies didn't have dog tags on them. It was so hot the Marines would take their dog tags off, or if they had them in their boots they'd take their boots off. So that was a problem and we weren't using that as our identification process. I had cross-referenced the other records [medical records?] we had with the dental records that I had for those who had come through for dental exams. There were three or four units under the BLT, whether they were TOW missiles or artillery, but there just wasn't one solid set of names. I spent about the next five days trying to figure out who was KIA, who was MIA, who was WIA, and who wasn't any of those categories.

I still have all that information; nobody ever took it from me. I've got all this information about everybody who died. I know their names, and I knew them all. It's a funny thing about being a dentist; you know everybody because you're their dentist. I had seen every one of those guys in the BLT; remember I was with them four months before the attack. I'm a pretty personal guy and I like to know who they are and where they're from. I'd pretty much seen all of them. The chaplains don't know everybody; they just know the guys who are having difficulties, and the physicians don't know everybody because these

are all young kids who don't really see a doc. So I'd had that benefit of at least seeing names. ?? What is this???

But the sad thing was we couldn't do it any quicker. It took us five or six days, and how that affected me on the back end was it took my wife seven days to get an International Red Cross message that I was alive. Thank God she had called me, because she would have had to wait seven days. I've always felt bad about the other families who probably had to wait that long.

Q: That phone call was just by chance?

A: It was pure chance, and my response was pure chance and it lasted about 20 seconds. My thought was, "I can't tell my wife this is happening, because nobody else knows." Well, they knew because we had CNN, but I didn't know that at the time. Of course, I didn't have the time to tell her anything anyway. It's probably best that I didn't say anything, but I wanted to make sure she knew Gill was okay, but I couldn't say anything about John Hudson.

…So you asked me about John. Dr. John Hudson, United States Navy Medical Corps lieutenant. He had gone to school with me at the Medical College of Georgia. I was a dental student; he was a medical student. When we came together, he had been the physician at the BLT for about six months. He was an interesting guy; he was a lot like Hawkeye [in M.A.S.H.]. He loved the people, but he didn't like the institution, and he would talk about it. He was from Georgia, and I was from Georgia. At that time, Sam Nunn was a Senator from Georgia. He would be so pissed off he would say, "I'm writing Sam Nunn. This is crazy. People are going to get killed out here." I mean, I can remember we'd get incoming fire and he'd write a letter. He'd go, "Ware, you're from Georgia. You need to sign this with me."

I said, "John, I'm not signing that with you."

So he sent a letter saying, "You don't know what's going on over here. Let me tell you what's going on. I feel I can write you because I'm one of your constituents. They've got us pinned down; they can shoot at us like fish in a barrel, and it's just crazy. We don't need to be around this airport because we're indefensible. I'm the one that has to take care of these patients, and I've already taken care of 50 of them." This was John's letter. He was just ranting and raving, and he did send it to the Senator.

Q: Did he get a response?

A: As far as I know he never got a response, but I feel certain he sent it. If I'm not mistaken either Sam Nunn or his representative was at his funeral in Georgia when they buried John.

He was a lot like Hawkeye. He was a good 'ole Georgia boy. He was a little bit overweight. I never will forget when we moved into our four-man room on the ship. I had been planning for weeks, probably months. "I need this. I don't need that. I'm going to be

gone six months. I need three of those because I'll just take one every two months." I had everything I needed. I had the foot powder. John comes in. He's got a sack and he just dumps it on the floor. Now, he is a physician -- but I go, "What do you have there?"

He says, "Hell, I don't know. What do you have over there? You've got some for me too, right? Because I didn't do it right. I packed last night."

I'm going, "I've been packing for months, John. We're going to be gone for six months."

So he just kind of had that attitude, good ole' boy. He never thought twice about telling the XO of the battalion what the XO didn't want to hear, because he felt like he was on an equal footing. It really is that situation with a physician and the ship's XO or CO; the physician can just about say anything, because they need to have that freedom, and John was a lot like that. I mean, I was a dentist; I didn't quite have that same relationship, except if it had something to do with dental.

His plan was to get out of the Navy as soon as he paid off his scholarship. His wife had a baby boy after he left. She came to Greece, and he was able to take some liberty for several days with his wife and newborn son, Will. That was the only time he ever saw his son. John spent a lot of time in educating the corpsmen and the troops about preventive medicine. From my perspective, I think Gill was a little bit more apprehensive of him; he appreciated him, but he kind of kept his distance. But I was, "Okay, I can tolerate you and I like you." But he made sure that he brought both of us into the medical treatment role. He wasn't high-faluting, "I'm better than you because I'm a physician and you're only a dentist." He recognized he needed us to provide the services of the BAS.

It became apparent that he hadn't walked out of the building and he wasn't in the hospitals. It took us until the next day to figure out who was in the hospitals. Some of those people had to be ID'd a second time. Seven of the 27 people who went to hospitals had died, and some of those bodies may have gone back to the French, because they thought they were French when they were really ours. All types of things started to happen. So the identification process of the bodies was going to be difficult.

The identification process took place in Germany, and when we communicated to decedent affairs, all we could say was, "We think this is who the person is, but we can't be sure." We shipped more than 241 bodies to Ramstein, Germany. There was also the guy who drove the truck, and there a guy named "Shuffles", a Lebanese who lived in the bottom of the building and sold snacks and was killed as well. I didn't identify him, but I had pulled a tooth for him as a humanitarian service weeks before. When they found this old man he was fairly intact, and from what they told me, they could tell from his jawbone that he had an extraction site. I said, "You know what? It could be Shuffles." Everybody knew he was in the building, and that I'd pulled a tooth of his.

But, back to John; it really took about two to three days to get the 94% solution on who was in the building and who wasn't. But it's the last two to three percent that's the most

important. “Where’s this person? Did they leave? Could they have gone to the hospital? Could they be one of the French paratroopers?” When you have so many bodies the identification process becomes fairly complicated. The FBI had fingerprints, but they were only able to identify about 54% of the people from fingerprints. So we had to use those dental records that Paul Dziadon was going to go after; 93% of the people were identified through their dental records, which was a pretty high percentage. Today we have DNA so it’s a little different.

By the next morning it became obvious that John was not in the hospitals, he hadn’t come through us, and he probably had died. They were digging out the ruins in a 24-hour per day operation and finding bodies and pieces of bodies. I told the people at the site, “I really want to see John Hudson when you find him.” I think it was the fourth day when they came across what they thought was him. Now you’re in decomposition; we had some rain, and it didn’t smell good, not only John, but other bodies still in the building. It took two weeks to flush through all the different materials there.

When I got there I said, “Where is he?”

“Well, we think he’s right here.” His arm was almost impaled into his forehead like this. I couldn’t say for sure that was John Hudson, but I was pretty sure. It was kind of a crushing injury, but not an obvious crushing injury. A lot of these people didn’t have obvious crushing injuries. I think the reverberation I talked about earlier may have had a big impact, because they didn’t bleed either. Their deaths could have been from the dust. But John’s hand was there, and I said, “That’s John.”

People who have been in combat or in these types of situations want to acknowledge it. You spend a moment reflecting, and then you move on because you’ve got work to do. I wanted that moment with him, because he was a personal friend of mine. I felt sure that he was dead and that was him in the building, but I’ve got to move on and do all these other things that need to be done. I’m not going to think about it anymore. I’m moving on.

Fast forward to the first or second week in January 1984. We had been back about a month, and I called John’s wife. I didn’t know her before. I mentioned that he was in the Medical College of Georgia when I was there, but we didn’t know each other; we just happened to be there at the same time. I asked her if I could come by and see her. She lived in Milledgeville, Georgia. I was back at Camp Lejeune, and I really wanted to touch base with her. So Francie and I drove to Milledgeville and met her and her mom and dad, and she showed me where they buried John on their farm in Milledgeville.

Her mom and dad had a lingering belief they had seen John in CNN photos; they were sure they had seen John alive helping patients. I don’t know what she’d seen because I didn’t see the CNN footage, but I said, “No, this never happened.”

There's grieving going on, and I'm grieving now; I have the time to grieve for my friend. His wife's grieving, and I was able to tell her things about John that she didn't know while he was deployed.

Gill and I both found that it was a very good thing emotionally that we got to know a lot of the wives who were in the Camp Lejeune area. With 241 people killed and probably half of them married, there was no one to tell them the story about their husband, because they were all in the same building. So Gill and I reached out to these people as a fellowship type of thing. It had a therapeutic effect for Gill and I, and it was also very important for them to have somebody to identify with. I did that for over eighteen months in a general way.

But back to John; I'm talking to Lisa, his wife, and we're sitting in the family room. I said, "No, he really did die. I can tell you that because I ID'd him." I told her exactly what I just told you, and I said, "He may have heard the explosion, but I think he died very quickly." I was trying to be honest with her. I said he was trapped in the rubble of the building, so I couldn't say that he wasn't crushed. "I think he might have heard it, is because his hand was right here."

(There is a pause.)

I need to compose myself, because this makes me tear up.

She jumped up out of the chair and left the room, and I thought, "Maybe I said too much." Ten seconds later she comes back with a picture, and she goes, "Did he look like this?" It's a picture of him sleeping with his hand right here. Then she knew that he really did die like that, and she could convince her mom and dad. It was a very emotional kind of thing.

Q: So he was asleep?
A: I think he was killed in his sleep…

(Pause)

Excuse me for having a little moment, but that's good…

I think he was killed in his sleep, as she and I both came to believe, which was comforting for her and for me as well. I think that's a good thing.

I guess you've both done a lot of interviewing. You're kind of tugging at my heart, but it's okay. I think when you live through these experiences, one of the things is that people really do have to share, and I think you know this. So I spent a lot of time sharing with the families of the people who died, and Gil did too. I think that's extremely helpful. And certainly, I still have those memories of John.

Q: It's helpful for you and the families when you have to grieve. I mean, you didn't have time to grieve at the time.

A: You don't have time to grieve.

Fast forward now to the things we did in Haiti, a whole different area and people we were not directly identified with, and similar types of issues. I'm sure my staff is still experiencing some of those feelings.

I shared with you some of my thoughts on the night before we left for Haiti. I knew what the crew didn't know, that this will change your life, and these experiences are going to be extremely personal. You have to be prepared, and you have to get up and move on. I'd seen two types of people who responded to tragedy. One group was those who couldn't get acclimated and get up to speed; they weren't comfortable with it. The other group was those who had become acclimated or who at least got their mind in gear and were able to get through their emotions at the moment of the tragedies we were seeing in Haiti.

I really drew strength from my experience 27 years before. I'd given a lecture on Beirut many times, and even though I just got emotional with Jan, I can usually hold it in. But I don't try to completely do that, because I think it's important. I always share the psychological point that no matter what you feel afterwards, you have to be mentally prepared to handle those situations in that moment and do away with your tears.

I may have talked about this with you, but in the prelude to the movie *Gods and Generals*, they show Stonewall Jackson talking to a little girl who dies. He's had thousands of men die under his command and he would ignore it; not because he wanted to but because he had to. But when the little girl died, that was the straw that broke the camel's back. I think humans neglect certain issues, but they need to come back and have a reality check on what's sad. John Hudson does that for me on occasion, and I don't mind talking about it.

Q: After all this was over and you came back home, were you ever debriefed about any of this? Or was it just something that you handled in your own way?

A: They send a SPRINT [Special Psychiatric Rapid Intervention Team], but what we realized was that the SPRINT team, which was three or four psychologists and psychiatrists, got there too late. What happens in a combat environment is most people encircle themselves with people who have had like experiences. This is why there are American Legion and Veterans of Foreign Wars halls around this country that were so successful in the '50s and '60s, because they allow you to talk about things without having to get too psychologically involved with exactly what they mean. They're stress relievers; they allow you to relieve those issues. I think people who are in a unit, whether it's in combat, or as in this case in Lebanon, need to be all together to talk about the things we saw. We did the same thing in Haiti when we were coming back; people had that moment to share with the people around them.

But when the SPRINT team came, but they didn't get to the ship until we were in Rota, Spain; and that was four or five weeks later. I don't think what they were going to provide as a group was as successful as they wanted it to be. But at that time, the term "post-traumatic stress syndrome", which is something that obviously occurred in combat veterans, didn't exist. [Suggest replace this with: *was not a [paramount issue in military medicine as it would be later.*] *The term emerged in the 1970s during the Vietnam War, and was added to DSM III in 1980.]*

Q: Well, I think it was finally added in 1980 in DSM three or four, but it didn't really catch on until much later.

A: Yes, I agree with you. So most of the people that came back were not debriefed and then they kind of moved on. Some people got in trouble. I had two dental techs: one was Richard Fly and the other one (I can't remember his name) got in trouble and got booted out. He was basically a good kid, but he was lazy. However, when the shit hit the fan, he was the first guy that I looked for, because he was the guy that could really make things happen. There were other corpsmen that got into some trouble afterwards that I always thought, "Gee, they probably just didn't quite get back on their feet." And that happens. I mean, we see that now with a lot of people coming back from the current war if they're not given some time.

Q: So the answer is no, you weren't debriefed?

A: No. I was operationally debriefed, but I wasn't necessarily debriefed any other way, except Gil and I always stayed very close friends. I mean, these are therapeutic measures that you just work with around the folks that you know.

Q: So you went to Rota from there?

A: We did, that was the wash down. ????what is this?

Q: You said you were operationally debriefed. How did that happen?

A: Admiral McKean [Thomas W.]??; you probably don't remember him but he was the IG in '83. [Cannot identify McKean; the Navy Medical Inspector in 1983 was Rear Admiral James A. Zimble.] From the 23rd of October to the 10th of November, which is the Marine Corps birthday, we were still on the ground. We loaded back onto the ships on the 11th, and by the 18th of November we hit Rota. McKean?? showed up in Rota. The last thing in the world that I wanted to do was to talk to an admiral; I wanted to go out and have a beer with my buddy Gil and the corpsmen I was with. This was three and a half weeks after the bombing, and we had moved on to the next phase of what needs to happen. But he's doing the medical review, plus we've got the Long Commission and all these other things going on. So he shows up and the question is, "Well, the physician was killed so nothing happened." *What does this mean??*

Colonel Geraghty goes, "No, I've got two dentists here that did a great job." McKean?? was actually a dentist, but he was the IG, so, "Let's find out what they did." So babbling as I'm doing now, he says, "Well, I need you to write a report for me." Gil was on another ship and I was in Rhota. I've got that report, but it's funny how poorly those

reports can be written when you don't really know how important they are. I'm just thinking, "I'm just one in a clog of people."

I said, "When do you need it?"

He says, "Well, I'm flying out tomorrow morning."

I'm like, "Oh God." I had been six months in Lebanon and I was ready to leave. But anyway, I sat down and diligently wrote this up the best that I could, the sequencing of what happened, and lessons learned. I didn't type at the time, so I had to go around and beg one of the corpsmen, "Would you please type this up for me?" He typed it up and I gave him McKean? a copy, and I still have a copy of it myself. (I probably should give it to you for the historical record.) He took that back and I think he used it for the Long Commission.

When I got back I was debriefed with a tape recorder, but they never used that information. Gil and I were probably emotional in that response, because I think we were very honest. If you're not honest you're not going to be quite as emotional. The debriefing was with the dental and medical guys. I remember going in as lieutenant and having all these people listen, and they didn't know what we had done, so they were just probably overwhelmed.

Years later, in 2000, I got a report from somebody who was on the dental side of the house. "Hey, I found this in the stacks. This is what you said back in 1983."

I said, "Wow, somebody really did hold on to it."

Q: Do you have a copy?
A: Well, when we first started talking I thought, "I'm going to pull that out." I think I have a copy of it somewhere, but it's like all the other crap; it's in my garage. If I find it, you'll be the first one I'll give it to.

Q: We'd be very interested in photographs or anything from that period.
A: I still have a lecture I give. I gave many, many lectures in the '80s. I was the key note speaker in the AMSUS meeting in '84, basically talking about medical preparedness and psychology of a mass casualty in the '80s. Then here I am the commander in 2010 in Haiti, and none of the people who picked me to be CO knew that. But I had that knowledge in my own mind. I know how this affects you; you can't avoid it. You have to at least get emotional about something, whether it's a little girl or when I talked about John.

I passed that information on to a lot of service members in 1990, when I was in Okinawa before Desert Shield/Desert Storm. I did it again in 2002 and 2003. I was down in Jacksonville, and I would get the corpsman together and give them a very personal talk like I just did (I wouldn't have quite as many tears). I'd say, "This is how it's going to be.

This is what you're going to have to do. This is how you need to move people," because there's some people who won't respond.

I think the Beirut bombing gave me a knowledge base for my command of the *Comfort.* I'm very sure of that. I think I was successful in making that work because I was fortunate enough to have those prior experiences. I wasn't blind going into Haiti. I knew what was coming for my staff. They probably still have a difficult time talking about it. We've all been debriefed multiple times. Some people don't want to be there, and that's fine. That's their privilege because it's so personal and it's so internalized, but I think it is important.

Q: It almost seems silly to ask you this question at the end of our interview, but it's 27 years since all this happened. You probably don't think about it every day, but you think about it a lot, I'm sure.

A: I do, in a positive way, but I don't know why it's positive. It's part of you. It's a touchstone, and a good touchstone. I think the things that I learned there about myself I still use to this day, especially in my Navy career. When I need the strength of understanding to get me through something, I can go back and touch that. I think the people who were on the Haiti mission, and most men and women who've been in combat can also touch this. I know that there are experiences that can terrify people and be so severe, perhaps it's the adrenalin response, that they want to get away from it. I think a lot of us who've had those experiences feel like we were challenged and we got through something that "but for the grace of God go I." Those are strengths.

I was lucky in Lebanon, because I walked away, but I lost a lot of good friends. Whenever I talk or think about those individuals, it's positive. There's probably not the right adjective in the English language, but there's something comforting about it. It's not something I want to avoid thinking about. It's something that when I dwell on for a moment, it's an emotion that I can't put a finger on.

Q: Historians look back at historical figures and wonder, "What would I have done? Would I have behaved as well as that individual? Would I have behaved as poorly as another individual?" In your case you're testing yourself. You're going back to the way you were in 1983. "How did I handle it? How would I handle that situation today," knowing you did it before; so that's a touchstone.

A: You have to give credit to John Hudson, the dental techs who did a good job, and to Gil Bigalow. I did an interview for *ADA News* two years ago, and one of my comments was, "I thought of Gil Bigalow as a little bit more mature than me." I really did, because I was 26, fresh out of dental school, and didn't have a lot of worldly experience. I was really excited about going with the corpsmen. I had raised my hand and volunteered, but when we got there and saw this gunfire and everything else, Gil was like, "What the hell am I doing here?" He had been in the Air Force, he'd spent a year in Vietnam, he'd had those experiences, but he didn't like to talk about them. He came in the Navy, and here he is again. We got along very well, and we were very close friends – "Frick and Frack".

About a week before the bombing, out of 800 in our group we counted eight killed and 54 wounded. That is a lot of people. The guy that lived next to me caught a sniper round through the throat that killed him; I had talked with him that morning. We were all a little bit anxious, and Gil called all the corpsmen together. It was fortuitous from his standpoint that we were worried about our own individual survival, because we were starting to see people around us being gunned down or mortared. He was able to give a very inspirational talk to the corpsmen and to me. It was just four or five minutes to say, "We've got to do it ourselves, because there's nobody else around who's going to help us." That was very effective.

He gave the same talk that I would give on the *Comfort* 27 years later when I told the staff, "This is going to change us. I've been here before. There are situations that you're going to be tested by. We don't know where this is going to go, but we are the beginning, the middle, and the end of medical care. There are ships off shore, but they may not be able to help us."

Q: Was it wonderful coming home to your wife?
A: Oh yes, it was. This happened on a Sunday, and by Monday evening the entire town of Savannah knew that one of their own, me, was there. The news people had already gone to my wife and interviewed her, and she was able to say, "I talked to Jimmy on the phone." I didn't know any of this was going on, but she had a sense that I was okay.

Of course, there's always things to do when you come home from a deployment. I think Gil and I were the last guys to leave the ship, because I was still worried about all this morphine that guy gave me, and Gil said, "I don't want that stuff."

Q: You should have deep-sized it while you had the chance.
A: Yes, I probably should have. Nowadays I might be a little bit smarter. But yes, it was good coming home.

Q: Would you ever be interested in going back to Beirut or Lebanon?
A: Yes, I think so. Like Vietnam veterans, I'd be curious to see what that area looks like. I've got pictures of what it looked like before we left in 1984. We were replaced by another MAU, which had a lot more combat engagements. They dug in for another four or five months and then President Reagan finally got us out of there. But yes, I would like to go back, but I'm not going to anytime soon because I've been reading about their politics and it's not looking good at all.

END OF INTERVIEW